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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

SEP 26 1994

The Honorable Albert Gore, Jr.
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

As required by section 1875(b) of the Social Security Act, this letter transmits to the Congress the Department of Health and Human Services' annual report on Medicare for Fiscal Year 1992.

The enclosed document also includes the report on the Medicare Supplemental Insurance Federal Certification Program, as required by section 1882(f)(2) of the Social Security Act (the Act); the report on the Utilization and Quality Control Peer Review Organization Program, as required by section 1161 of the Act; and the report of the Joint Commission on Accreditation of Healthcare Organizations, as required by section 1875(b) of the Act.

I am sending a similar letter to the Speaker of the House of Representatives.

Sincerely,

Donna E. Shalala

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

SEP 26 1994

The Honorable Thomas S. Foley
Speaker of the House of
Representatives
Washington, D.C. 20515

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Donna E. Shalala

Enclosure

MEDICARE ANNUAL REPORT TO CONGRESS

Fiscal Year 1992

Including Reports On The:

Medicare Supplemental Insurance
Federal Certification Program

Medicare Validation Surveys of Hospitals
Accredited by the Joint Commission of
Accreditation of Healthcare Organizations

Utilization and Quality Control
Peer Review Organization Program

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

TABLE OF CONTENTS

		Page
INTRODUCTION		
EXECUTIVE SUMMARY		1
I.	THE MEDICARE POPULATION AND BENEFITS	5
II.	UTILIZATION AND QUALITY CONTROL	10
III.	ENCOURAGING COMPETITION AND CHOICE	15
IV.	EFFICIENT OPERATION OF MEDICARE	19
V.	RESEARCH AND DEMONSTRATIONS	31
VI.	PROMOTING IMPROVEMENT	43
VII.	REPORTS AND PUBLICATIONS	46
VIII.	REGULATIONS PUBLISHED	50
IX.	Medicare Supplemental Insurance Federal Certification Program Report	56
X.	REPORT FOR FISCAL YEARS 1991 AND 1992 ON MEDICARE VALIDATION SURVEYS OF HOSPITALS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS	60

ABBREVIATIONS AND ACRONYMS

AAPCC	Adjusted average per capita cost
AFDC	Aid to Families with Dependent Children
AHA	American Hospital Association
AHPB	Adjusted historical payment basis
ANSI	American National Standards Institute
APG	Ambulatory patient group
ASC	Ambulatory surgical center
ATB	All trunks busy
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMP	Competitive medical plan
CMHC	Community mental health center
CNO	Community nursing organization
CoPs	Conditions of participation
CPEP	Contractor performance evaluation program
CY	Calendar year
DHHS	U.S. Department of Health and Human Services
DME	Durable medical equipment
DMERC	Durable medical equipment carrier
DRG	Diagnosis related group
EOMB	Explanation of Your Medicare Part B Benefits
EMC	Electronic media claim
ESRD	End-stage renal disease
FFP	Federal financial participation
FFS	Fee for service
FI	Fiscal intermediary
FICA	Federal Insurance Contributions Act
FQHC	Federally qualified health center
FY	Fiscal year
GNP	Gross national product
GPCI	Geographic practice cost index
HCFA	Health Care Financing Administration
HCPP	Health care prepayment plan
HHA	Home health agency
HI	Hospital Insurance (Medicare Part A)
HMO	Health maintenance organization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LSC	Life Safety Code
LTC	Long-term care
MR	Medical review
MSP	Medicare Secondary Payer Program
MSIS	Medicaid statistical information system
M-TAG	Medicare Technical Advisory Group
MTS	Medicare transaction system
MVPS	Medical volume performance standards
NCH	National claims history

NTIS	. . .	National Technical Information Services
OBRA	. . .	Omnibus Budget Reconciliation Act
OPA	. . .	Office of Public Affairs
OCCPP	. . .	Office of Coordinated Care Policy and Planning
OPHCOO	. . .	Office of Prepaid Health Care Operations and Oversight
ORD	. . .	Office of Research and Demonstrations
P.L.	. . .	Public law
PPS	. . .	Prospective payment system
PRO	. . .	Peer review organization
RFP	. . .	Request for Proposal
RVU	. . .	Relative value units
SAs	. . .	State agencies
SFAS	. . .	Statement of Financial Accounting Standards
SHMO	. . .	Social health maintenance organization
SMI	. . .	Supplementary Medical Insurance (Medicare Part B)
SNF	. . .	Skilled nursing facility
SSA	. . .	Social Security Administration
SSI	. . .	Supplemental Security Income

INTRODUCTION

Medicare is the health benefit program authorized by Social Security Act Title XVIII, "Health Insurance for the Aged and Disabled." Established by the Social Security Amendments of 1965, it was legislated as a complement to Social Security retirement, survivors and disability benefits. When implemented in 1965, Medicare covered most persons 65 years of age and older. Since that time, Congress has broadened the program to cover the disabled, persons with end-stage renal disease (ESRD), and certain others who elect to buy into the program. The program is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS). The Social Security Administration (SSA), also a part of HHS, provides information about the program and handles enrollment.

Medicare consists of two separate but complementary insurance programs: Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Hospital Insurance helps pay for medically necessary inpatient care provided by a Medicare-approved hospital, skilled nursing facility, home health agency or hospice program. Supplementary Medical Insurance helps pay for medically necessary physician services, outpatient hospital services, certain home health care services,laboratory tests, durable medical equipment, some therapy services and certain other services not covered by Part A. Part A is financed through the Federal Insurance Contributions Act (FICA) tax paid by employees, employers and the self-employed. Part B, in which enrollment is voluntary, is financed from the monthly premiums paid by enrollees and from Federal general revenues.

The Medicare program is administered through private organizations, usually commercial insurance companies, which are referred to as contractors. Contractors' primary responsibilities include processing claims and making benefit payments. Contractors that handle Part A claims are called "fiscal intermediaries" while those who handle Part B claims are called "carriers." Contractors also perform certain functions to ensure the appropriateness of Medicare payments and protect the Medicare trust funds.

With Medicare outlays in excess of $132.2 billion in FY 1992, and total outlays in excess of $200 billion with the addition of Medicaid expenditures, HCFA was the third-largest source of Federal outlays, surpassed only by Social Security and Defense. Agency programs accounted for 33 cents of the average dollar spent on health care in the United States during the fiscal year, making it the world's largest health insurer.

EXECUTIVE SUMMARY

BENEFICIARIES

During FY 1992, the number of Medicare beneficiaries increased by approximately 709,000, from 34.9 million to 35.6 million. Of the total number of beneficiaries, 34.9 million were residents of the United States, 455,000 lived in U.S. commonwealths and territories, and 271,000 resided in other countries.

Approximately 95 percent of the Medicare beneficiaries residing in the United States, 68 percent of those residing in U.S. commonwealths and territories, and 15 percent of those residing in foreign countries were enrolled in both Medicare Hospital Insurance (Part A) and Medicare Supplementary Medical Insurance (Part B).

BENEFIT PAYMENTS

Medicare benefit payments totaled about $129.2 billion in FY 1992, or 13.4 percent more than the benefit outlays for the previous fiscal year. Benefits paid under Part A amounted to $80.6 billion, while those paid under Part B totaled $48.6 billion. Inpatient hospital care accounted for $69 billion, or nearly 86 percent of Part A spending. Physician services, at more than $32 billion, accounted for 66.5 percent of Part B spending during the fiscal year.

PROGRAM FUNDING

In FY 1992, 87 percent of the financing for Part A was derived from employment taxes paid by workers and their employers and by self-employed individuals. The remainder came from Federal general revenues and other sources. Part B was financed by three sources: (1) premium payments from enrollees (24 percent); (2) contributions from general revenues (73 percent); and (3) interest on balances in the SMI Trust Fund (3 percent). The Part B monthly premium was $31.80 in CY 1992.

HEALTH CARE PROVIDERS

At the close of the fiscal year, 5,527 short-stay and 319 long-stay hospitals with about 1.2 million beds were participating in Medicare, as were 10,589 skilled nursing facilities (SNFs), 207 comprehensive outpatient rehabilitation facilities, 6,175 home health agencies (HHAs) and 4,919 independent laboratories. Other participating health care providers included 1,476 ambulatory surgical centers, 1,199 hospices, 899 rural health clinics and 2,269 end-stage renal disease (ESRD) facilities or units providing services to Medicare

beneficiaries requiring maintenance dialysis or kidney transplants.

PARTICIPATING PHYSICIANS AND MEDICAL SUPPLIERS

About 52 percent of the physicians (407,495) and 24 percent of the medical suppliers (29,791) serving Medicare beneficiaries signed participation agreements with HCFA for CY 1992. Physicians and suppliers may choose each year to participate in Medicare and to accept assignment on all Medicare claims. Nonparticipating physicians and suppliers can decide whether to accept assignment on a claim-by-claim basis. Participating physicians and suppliers agree to accept Medicare approved amounts as payment in full for their services regardless of the actual charges.

QUALITY OF CARE MONITORED

Peer Review Organizations (PROs) under the aegis of HCFA concentrated during the fiscal year on monitoring the quality of care afforded Medicare beneficiaries and ensuring compliance by Medicare providers with the provisions of the prospective payment system (PPS). Major areas scrutinized by the 53 PROs included hospital admissions, readmissions and transfers, accuracy of coding, and day- and cost-outlier cases. PROs identified 524 physicians and 122 providers with potential sanctionable violations during the fiscal year and sent 497 notices informing them of the possibility of being sanctioned. Sanctions imposed by the Office of Inspector General resulted in 4 physicians being excluded from the Medicare program for varying periods of time. In addition, a monetary penalty was imposed on one physician.

PREPAYMENT PLAN OPTION EMPHASIZED

HCFA maintained emphasis throughout the year on the importance of providing Medicare beneficiaries with an alternative to traditional fee-for-service health care by promoting prepayment health plans as an option for beneficiaries to consider in determining how they will receive Medicare-covered services. At the end of the fiscal year, about 2.3 million Medicare beneficiaries were enrolled in 174 prepaid health plans that had either a contract or agreement with HCFA. That was an 8.2 percent increase over the enrollment figure for FY 1991.

MEDICARE CLAIMS

Medicare intermediaries received 101 million Part A claims in FY 1992 compared to 91.9 million in FY 1991, and Medicare carriers received 550 million Part B claims, an increase of 49 million over the FY 1991 figure. Approximately 80 percent of the Part A and 50 percent of the Part B claims were submitted via electronic media. HCFA estimated FY 1992 savings of $36 million

from increased electronic submissions.

BENEFICIARY INQUIRIES

Medicare intermediaries handled 1,885,844 beneficiary inquiries and 2,391,744 provider inquiries during the fiscal year. During the same period, Medicare carriers received 20,858,575 beneficiary inquiries and 13,520,733 provider inquiries.

OPERATIONAL REVIEWS

Operational reviews undertaken during the fiscal year included a review of the effectiveness of nationally mandated and local carrier review screens, a review of the adjudication process for peer review organization (PRO) denials/adjustments, and a review of the medical necessity and reasonableness of payments for certain Medicare hospital outpatient services. Physician global service package studies for selected surgeries were continued during the fiscal year and four new global service package studies were implemented.

Various oversight activities undertaken by HCFA and the Medicare contractors during the fiscal year to protect the Medicare trust funds resulted in savings to the program of more than $5 billion. This activity has been cost-effective, with FY 1992 program savings of about $14 for each administrative dollar expended.

MEDICARE SECONDARY PAYER PROVISIONS

The Medicare Secondary Payer (MSP) provisions, which cost $90.2 million to administer, produced more than $2.809 billion in savings, for a rate of return of 31:1. The provisions determine when Medicare is a secondary payer and another insurer is the primary payer of a Medicare beneficiary's claims for covered medical services and supplies. Other Medicare payment safeguards accounted for about $2.2 billion in savings during the fiscal year.

CONTRACTOR PERFORMANCE EVALUATION PROGRAM

The Contractor Performance Evaluation Program (CPEP) contains performance standards designed to prevent the inappropriate expenditure of Medicare funds. During FY 1992, 25 standards were applied in measuring the performance of fiscal intermediaries and 27 were applied in measuring the performance of carriers. Four of the 54 intermediaries and nine of the 48 carriers failed to meet the CPEP standards. Those falling short of the standards were required to implement plans to improve their performances.

NEW PROJECTS FUNDED IN FY 1992

HCFA's Office of Research and Demonstrations funded numerous new grants, contracts, and cooperative agreements during the fiscal year. The projects include research, demonstration and evaluations in the areas of reimbursement, coverage, eligibility and program management approaches, as well as research and evaluation studies of the impact of HCFA programs on quality health care services and the economics of the health care industry.

CHAPTER I

THE MEDICARE POPULATION AND BENEFITS

INTRODUCTION

Medicare enrollment increased 2 percent in FY 1992 from 34.9 million to 35.6 million, and benefit outlays rose 13.4 percent from $113.9 billion to $129.2 billion (Table 1). One out of every seven Americans had some Medicare coverage during the fiscal year, which means that the Medicare program covered about 14 percent of the United States resident population of 255.1 million. Spending on program administration was nearly $2.9 billion for the fiscal year, or about 2 percent of total Medicare outlays. Another $230 million was spent on peer review organization (PRO) activities.

MEDICARE BENEFICIARIES

Approximately 709,000 individuals were added to the Medicare rolls during the fiscal year. About 526,000 of the new enrollees were 65 years of age or older, bringing to 32 million the number of elderly beneficiaries, and 183,000 were younger disabled persons, increasing the number of disabled beneficiaries to 3.6 million. Included among the disabled were 72,000 with end-stage renal disease who must meet eligibility requirements different from those for other disabled beneficiaries.

Of the approximately 35.6 million beneficiaries, 34.9 million were residents of one of the 50 States or the District of Columbia, 446,000 resided in Puerto Rico, 8,000 in the Virgin Islands, 804 in Guam, and 242 in American Samoa, the Northern Mariana Islands and other outlying areas. Another 271,000 resided in foreign countries. Ninety-five percent of the Medicare population in the 50 states and the District of Columbia, 68 percent of the beneficiaries in U.S. commonwealths and territories, and 15 percent of the beneficiaries in foreign countries were enrolled in both Medicare Part A and Part B.

Women accounted for 57.6 percent of the total Medicare population, 59.7 percent of the beneficiaries 65 years of age and older, and 38.2 percent of the disabled enrollees. The percentage of disabled who are men, while down slightly in FY 1992 to 61.8, has remained relatively constant since FY 1980 as has the percentage of aged who are men. Minorities represent a growing proportion of the Medicare population. In FY 1992, 4.2 million Medicare enrollees were other than white. This represented 11.9 percent of the Medicare population, an increase of 2 percent over FY 1980 when 9.9 percent of beneficiaries were non-white. While non-whites made up only 10.5 percent of aged beneficiaries, 23.9 percent of the disabled beneficiaries were other than white, an increase of more than 1 percent over the figure for the previous

fiscal year.

A significant demographic trend that has and will continue to affect Medicare is the increasing median age of beneficiaries. In FY 1973, about 1.7 million beneficiaries, or 7.8 percent of the elderly population, were 85 and older. In FY 1992, 3.5 million, or 11 percent of the aged population, were in the 85-and-over category. The aging of the Medicare population is an important economic factor as older beneficiaries generally require greater and more intense health care services than do younger beneficiaries.

BENEFIT EXPENDITURES

Medicare benefit payments for FY 1992 totaled about $129.2 billion, or 13.4 percent more than for the previous fiscal year. Benefits paid under Medicare Part A increased 17.7 percent, while those paid under Medicare Part B increased 6.8 percent. Benefit payments for FY 1992 were broken down as follows:

* Part A--$80.6 billion
* Part B--$48.6 billion

Part A spending was divided among its components as follows:

Benefit	FY 1991	FY 1992	% Change
	(Dollars in Millions)		
Inpatient Hospital	$60,775	$69,007	13.6
Skilled Nursing Facility	2,459	3,692	50.1
Home Health	4,787	7,077	47.8
Hospice	465	808	73.8
Total	$68,486	$80,584	17.7

Of all purchases, hospital care, at $69 billion, accounted for the largest portion of Medicare spending during the fiscal year. Fifty-three percent of Medicare's total benefit expenditures and nearly 86 percent of Part A outlays went for inpatient hospitalization. There were 322 hospital discharges per 1,000 beneficiaries in FY 1992 compared with 314 discharges per 1,000 beneficiaries for the previous 12-month period. Moreover, the 2,757 days of care per 1,000 enrollees in FY 1992 were 10 more than in FY 1991. The average length of a hospital stay was 8.6 days, down from 8.7 days in FY 1991. Medicare beneficiaries are entitled to 90 days of inpatient hospital care in each benefit period. A benefit period begins the first day a beneficiary receives Medicare-covered services in a hospital. It ends when the beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days. There is no limit to the number of benefit periods a beneficiary can have. In addition

to the 90 days of inpatient hospital care, a beneficiary also has 60 "lifetime reserve days" which can be used whenever more than 90 days of hospitalization are required. Once used, lifetime reserve days are not renewed.

Medicare paid $3.7 billion for skilled nursing facility (SNF) services in FY 1992, or 50 percent more than in FY 1991. The cost of SNF services accounted for nearly 5 percent of Part A outlays during the year. Medicare beneficiaries are entitled to 100 days of SNF care during a benefit period, provided the SNF admission follows an inpatient hospital stay of at least three consecutive days and certain other conditions are met.

The $7.1 billion spent on home health services during the fiscal year was 47.8 percent higher than home health outlays in FY 1991. However, it accounted for only 9 percent of Part A spending. Part A covers home health visits with no prior hospitalization requirement. The care needed must include part-time or intermittent skilled nursing care, physical therapy and speech therapy. The patient must be homebound to qualify for the Medicare home health benefit.

For the fifth consecutive fiscal year, the greatest percentage increase in any single category of Medicare spending was for hospice care, which increased 73.8 percent, from $465 million in FY 1991 to $808 million. This represented 1 percent of Part A benefit payments. The rise was primarily due to the increased availability and acceptability of hospice care, which accounted for $4 million in Medicare spending when it was introduced as a benefit in 1984. Part A of Medicare pays for hospice care when a physician certifies that a patient is terminally ill; the patient chooses hospice care instead of standard Medicare benefits for the terminal illness; and care is provided by a hospice program approved by Medicare.

SUPPLEMENTARY MEDICAL INSURANCE

Part B, which, at $48.6 billion, was 6.9 percent higher than in FY 1991, was broken down as follows:

Benefit	FY 1991	FY 1992	% Change
	(Dollars in Millions)		
Physicians	$31,049	$32,304	4.0
Outpatient Services	9,232	10,671	15.6
Group Practice	3,411	3,810	11.7
Independent Laboratory	1,692	1,735	2.5
Home Health	72	75	4.2
Total	$45,456	$48,595	6.9

The $32 billion spent for physician services was 4 percent more than the FY 1991 outlay and represented 66.5 percent of Part B spending for the fiscal year. Part B generally pays 80 percent of Medicare-approved charges for medical services after the beneficiary pays the first $100 in approved charges each calendar year. Medicare spending for outpatient services increased from $9.2 billion in FY 1991 to $10.7 billion. Outpatient services provided by hospitals are covered under Part B.

The 11.7 percent increase in outlays for group practice plans, rising from $3.4 billion to $3.8 billion, reflects the increased number of Medicare beneficiaries enrolled in prepayment plans, such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). This category of expenditures is only 7.8 percent of total Part B expenditures. There was a 4.2 percent increase in home health benefit outlays from $72 million to $75 million. This is relatively insignificant as most home health care is covered by Medicare Part A. During the fiscal year the percentage of Part B spending for independent laboratory services increased 2.5 percent from $1.69 billion in FY 1991 to $1.74 billion.

PROVIDERS

The number of participating hospitals decreased from 6,487 in FY 1991 to 6,457 in FY 1992. During this period the number of short-stay hospitals slipped from 5,480 to 5,427 while the number of long-stay hospitals increased from 300 to 319 and the number of psychiatric hospitals climbed from 707 to 711. At the same time, the number of Medicare-participating SNFs rose from 9,674 to 10,589 and the number of SNF beds increased by about 30,000 to 597,000.

Other providers participating in Medicare during the fiscal year included 6,175 home health agencies, 4,919 independent laboratories, 2,269 end-stage renal disease (ESRD) facilities, 207 comprehensive outpatient rehabilitation facilities, 1,476 ambulatory surgical centers and 1,199 hospices.

PROGRAM FUNDING

Under the Social Security Act, the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds are administered by two boards of trustees, each with the same five members. Three members serve in an ex officio capacity: The Secretary of Treasury, who by law serves as managing trustee of both funds, the Secretary of Labor, and the Secretary of Health and Human Services. Two public members are nominated by the President for four-year terms subject to confirmation by the Senate. The Administrator of HCFA serves as secretary of both boards.

The primary source of Part A financing (about 87 percent) was derived from payroll taxes paid by workers and their employers and by self-employed individuals. The remainder came from Federal general revenues for certain insured individuals who attained age 65 before 1975, premium payments for voluntarily enrolled individuals, transfers from the Railroad Retirement Board, military service credits, and interest on accumulated funds.

Part B was financed by three sources: (1) premium payments from enrollees, (2) contributions from general revenues and (3) interest on trust fund reserves. The Part B premium under the Tax Equity and Fiscal Responsibility Act and the Deficit Reduction Act was set at 25 percent of program costs. In FY 1992, beneficiary premiums covered 24 percent, and government contributions 73 percent, of the required funding for Part B. Interest on trust fund reserves covered the balance. The monthly Part B premium was $31.80 in CY 1992.

More detailed information about the status of the trust funds, showing income, disbursement and future projections, is contained in the 1992 annual reports of the trustees of the respective funds.

Chapter II

REPORT TO CONGRESS ON THE UTILIZATION AND QUALITY CONTROL PEER REVIEW

BACKGROUND

Section 1161 of the Social Security Act (the Act) requires that HCFA give to Congress a full and complete annual report on the administration, impact and cost of the Utilization and Quality Control Peer Review Organization (PRO) program. This report includes the following items mandated by section 1161 of the Act: (1) statistics on PROs participating in the program, (2) the institutions/physicians/beneficiaries subject to PRO review, (3) total Federal expenditures, (4) the number of penalties and sanctions imposed and (5) criteria for review.

PROs are charged by law to ensure that services rendered to Medicare beneficiaries meet professionally recognized standards of care and are medically necessary and provided in the most appropriate setting (e.g., acute care hospital vs. skilled nursing facility (SNF) or a lesser level of care). Most PRO review is done retrospectively, that is, after the patient has been discharged from the hospital, ambulatory surgical center (ASC), or other setting. After the beneficiary is discharged from the hospital and payment is made to the hospital, a sample of paid bill data is sent by the fiscal intermediary to the PRO. The PRO selects a sample for review and requests the relevant medical records from the hospital.

First level PRO reviewers, primarily nurses, use criteria for review which are developed by local practicing physicians to approve payment for cases which clearly meet acceptable standards. They refer questionable cases to PRO physician reviewers. If the physician reviewer determines that there is a potential utilization or quality problem, the PRO will offer the physician/provider an opportunity to discuss the case and submit additional information, if any is available. If the PRO physician reviewer determines that the care was not medically necessary or that it should have been provided in another setting, the PRO will issue a payment denial.

Only the PRO physician reviewer may deny a case, and denials may be made only after the physician/provider has been given an opportunity to discuss the case with the PRO. If, after the discussion, the PRO physician determines that there is a confirmed quality problem, the PRO will initiate corrective action. PRO reviewers also validate that the diagnostic and procedural information provided by the physician and reported by the hospital is correct and results in the correct diagnosis related group (DRG) assignment. This practice ensures that correct Medicare payment is made for care and services rendered.

TOTAL FEDERAL EXPENDITURES

In FY 1992, $185.9 million was obligated for the 53 PRO Medicare contracts. Under title XIX of the Act, States have the option of contracting with PROs to review Medicaid services. If a State contracts with a PRO, the State receives Federal financial participation (FFP) funding at 75 percent of the cost of a review. During the fiscal year, 37 PROs had contracts totaling $38.3 million to review Medicaid services. The FFP expenditures for these reviews totaled $28.4 million (Table 2).

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) contracts with PROs, including PROs with contracts under the Medicare program, to review services furnished to CHAMPUS beneficiaries. In FY 1992, the expenditures for this program amounted to $3 million. Funding for this program is transferred on an annual basis to the Department of Health and Humans Services from the Department of Defense.

PENALTIES AND SANCTIONS

During the fiscal year, the PROs identified 524 physicians and 122 providers with potential sanctionable violations under section 1156 of the Act and sent 497 notices informing them of the possibility of being sanctioned. The Office of Inspector General imposed 5 sanctions based on PRO recommendations. Of the 5 sanctions, 4 physicians were excluded from the Medicare program for varying periods of time, and a monetary penalty was imposed on 1 physician.

STATISTICS ON PROs PARTICIPATING IN THE PROGRAM

At the end of the fiscal year, 42 of the 53 PROs (a PRO in each of the 50 States[1], District of Columbia, Puerto Rico, and the Virgin Islands) were operated as in-State organizations. The other 11 contracts were operated by a PRO located in another State, with medical review activities performed by physicians practicing in the particular State. (For example, the Rhode Island PRO has the contract for the State of Maine and utilizes physicians practicing in Maine.)

INSTITUTIONS/PHYSICIANS/BENEFICIARIES SUBJECT TO PRO REVIEW

A sample of Medicare admissions in 5,430 acute and 1,053 specialty hospitals were reviewed for utilization and quality by PROs during the fiscal year. In addition, PROs performed utilization and quality review of ambulatory surgery performed in

[1]Hawaii and the PRO area of American Samoa/Guam and the commonwealth of the Northern Mariana Islands are combined into one contracting area.

Table 2

PROs WITH CONTRACTS TO REVIEW MEDICAID SERVICES

State	Total Amount	Federal Share	State Share
Alaska	535,294	401,470	133,823
Arizona	262,803	197,103	65,700
Arkansas	1,478,178	1,108,634	369,544
Connecticut	531,153	398,364	132,789
Colorado	3,486,993	2,615,245	871,748
Delaware	171,167	128,375	42,792
District of Columbia	457,485	343,114	114,371
Florida	267,097	200,323	66,774
Idaho	587,952	440,964	146,988
Illinois	2,433,915	1,825,436	608,479
Indiana	2,736	2,052	684
Iowa	2,846,532	2,134,899	711,633
Kansas	1,641,861	1,231,395	410,466
Kentucky	2,956,003	2,217,004	738,999
Maryland	2,829,878	2,122,409	707,469
Michigan	1,333,079	999,810	333,269
Minnesota	811,761	608,821	202,940
Mississippi	1,591,521	1,193,641	397,880
Montana	316,400	237,301	79,099
Nebraska	887,246	665,434	221,812
Nevada	708,684	531,514	177,170
New Hampshire	278,300	208,726	69,574
New Mexico	893,273	669,955	223,318
New York	2,969,125	2,226,843	742,282
North Carolina	775,261	581,447	193,814
North Dakota	146,030	109,523	36,507
Ohio[1]	1,286,822	643,412	643,410
Oklahoma	916,883	687,663	229,220
Oregon	158,756	119,067	39,689
South Carolina	410,336	307,752	102,584
South Dakota	156,417	117,313	39,104
Tennessee	1,599,491	1,199,618	399,873
Vermont	195,854	97,928	97,926
Washington	80,972	60,729	20,243
West Virginia	873,120	654,840	218,280
Wisconsin	1,245,502	934,128	311,374
Wyoming	181,865	136,399	45,466
Total	**38,305,745**	**28,358,652**	**9,947,093**

[1]The Ohio PRO reviews Medicaid services for the State of Kentucky.

ASCs (1,482) and hospital outpatient areas (approximately 5,430). PROs also performed:

- Quality reviews, on a sample basis, of SNFs (10,643) and home health services (6,240.)
- Quality reviews of services rendered to Medicare enrollees of risk-based HMOs/CMPs;
- Prior approval reviews of all cases that involved an assistant at cataract surgery or hospital notices of noncoverage that needed PRO concurrence.
- Reviews of care provided to beneficiaries who filed quality-of-care complaints.

The PROs completed 2,062,399 reviews in FY 1992. They denied 2.8 percent of the cases reviewed retrospectively and about 2.6 percent of the cases requiring preadmission or preprocedure authorization. There were more than 1,039,342 cases that failed one or more generic quality screens. Of these, 42,247 were confirmed as quality problems. Although every physician who treats hospitalized Medicare beneficiaries has cases that are subject to review, PROs did not specifically review physician services rendered in the office setting during the fiscal year.

CRITERIA FOR REVIEW

The PROs must develop review criteria which reflect local standards of medical practice in their areas and these criteria must be accepted by HCFA. Review criteria contain the generally recognized reasons which would justify a patient's admission to a hospital or the need for a surgical procedure. The criteria are used by PRO reviewers (usually nurses) to determine whether Medicare approval can be given. Cases which fail to meet the criteria are referred to PRO physicians, who are actively practicing physicians in the PRO area. The physician reviewers make their determinations regarding the necessity, appropriateness and quality of care for each questionable case primarily on the basis of their own knowledge, experience and training, and on the basis of discussions with the attending physicians. PRO denials are never based on criteria alone.

In addition, all PROs apply discharge screens and the generic quality screens to all cases retrospectively reviewed under their contracts. The generic quality screens are specific to the type of setting the PRO is reviewing and are indicators used by nonphysician reviewers to identify cases of possible poor quality care. Any case that fails one or more of the screens and is a potential quality problem will be further evaluated by PRO physicians who will determine whether the care met professionally

recognized standards of quality. These determinations are made on a case-by-case basis using the patient's medical record and any additional information available.

CHAPTER III

ENCOURAGING COMPETITION AND CHOICE

PROGRAM MANAGEMENT

HCFA has continued to make substantial progress in providing Medicare beneficiaries with an alternative to traditional fee-for-service Medicare through contracts with prepayment plans. At the close of FY 1992, HCFA had contracts with 174 prepaid health plans with an aggregate enrollment of nearly 2.3 million Medicare beneficiaries, an increase of 8.2 percent over FY 1991. Thirteen new risk-based contracts were approved during the fiscal year, and five existing Medicare-contracting plans were permitted to expand their service areas.

Enrollment in plans with Medicare risk-based contracts reached more than 1.5 million by the end of the fiscal year, an increase of almost 15 percent over FY 1991. At the same time, enrollment in cost-based plans was 135,402. Another 628,612 Medicare beneficiaries were enrolled in health care prepayment plans (HCPPs) that had agreements with HCFA and 21,703 were enrolled in four prepaid plans with other types of contractual arrangements. Total payments to prepaid health plans in FY 1992 amounted to $6.910 billion.

Following is a breakdown of prepaid health plan Medicare contracts as of the end of FY 1992:

Type of Contract	Number of Plans	Enrollees
Total prepaid contracts	174	2,291,325
Risk	90	1,505,608
Cost	26	135,402
Other (Social HMOs)	4	21,703
HCPPs	52	628,612

HCFA continued its commitment to provide greater plan management and oversight at both the regional and central office levels. Oversight activities included: (1) monitoring HCFA's objective to ensure quality, access and efficiency in risk-contracting HMOs and CMPs, (2) expanding the role of HCFA's 10 regional offices in plan operations, (3) improving the plan monitoring process, (4) evaluating research data to better understand prepaid contracting activities for development of future policies, and (5) initiating a national educational and informational campaign to ensure that all beneficiaries receive

sufficient information to make informed choices among an array of health care options.

TRANSFER OF RESPONSIBILITIES

HCFA's Office of Prepaid Health Care Operations and Oversight (OPHCOO) went through a realignment of duties during the fiscal year to strengthen both the monitoring of Medicare-contracting prepayment plans and the enforcement process. This entailed the shifting of responsibility for plan monitoring and and the reviewing of contract applications from OPHCOO to the regional offices, which, because of their proximity to the plans, are in a better position to identify potential problems and to address them in a timely fashion. To facilitate this transfer of responsibilities, OPHCOO conducted three major training workshops in three different areas of the country for clusters of regional offices. The three-day training were conducted by OPHCOO staff using materials specifically prepared for the transfer of responsibilities.

FY 1992 REGULATIONS AFFECTING PREPAID PLANS

The following regulation affecting Medicare-contracting prepaid health organizations was published in the Federal Register by HCFA during FY 1992:

- A final rule to revise Title 42, Part 417 of the Code of Federal Regulations. This regulation is the first of several technical revisions of Part 417 in order to better address recent statutory additions and revisions affecting prepaid health plans. The provisions of this rule expand the number of sections in Part 417 and remove duplicative sections. In addition, the regulatory language is now standardized and obsolete sections of the Code have been deleted. (Published October 17, 1991).

Several additional rules were circulated during FY 1992 in preparation to their publication early in FY 1993. They were:

- A proposed rule to expand the appeal rights of beneficiaries who are enrolled in Medicare-contracting prepaid health organizations. The rule will ensure that enrollees in Medicare risk, cost and health care prepayment plans have the same appeal rights as beneficiaries under fee-for-service Medicare. (Proposed rule published October 7, 1992).

- A proposed rule to restrict the types of incentives that prepaid health care plans may offer to contracting physicians. The rule will require prepaid health plans to provide details of physician incentive arrangements, prohibit payments that may induce physicians to limit

medical services and require organizations that place their physicians or physician groups at "substantial" financial risk to provide stop-loss protection and conduct beneficiary surveys. (Proposed rule published December 14, 1992).

- An agency-wide final rule to implement the advance directives mandated by Congress requires prepaid health care organizations to provide certain information to beneficiaries at the time of enrollment. The information must define the State's laws and the organization's policies regarding the enrollee's right to make decisions concerning the refusal or acceptance of medical treatment. (Interim Final Rule published March 6, 1992).

- Another significant regulatory activity conducted during FY 1992 was the analysis of public comments pertaining to a proposed regulation which will broaden the Secretary's authority to impose sanctions and penalties on prepaid health plans. This rule, promulgated in cooperation with the Office of the Inspector General, will give the Department increased flexibility to take action against HMOs and CMPs for failure to provide medically necessary service or for improper enrollment, marketing, or reimbursement practices. The rule also increases the maximum allowable civil monetary penalty that can be imposed for violations. (NPRM published July 22, 1991).

NATIONAL HEALTH CARE EDUCATION CAMPAIGN

HCFA's Office of Coordinated Care Policy and Planning (OCCPP) devised and implemented during the fiscal year a national campaign designed to help individuals make better health care decisions, encourage greater participation in Medicare's alternative health care delivery system, and support similar efforts in the private sector.

The initiative included the development of publications and outreach programs for beneficiaries, beneficiary-related groups and employers. The programs included the convening of HCFA's first beneficiary conference to share with interested groups and individuals the Agency's efforts to provide alternative health care products, produce materials and information to explain these choices and generally upgrade communications with the private sector.

OCCPP staff also participated in conferences sponsored by beneficiary organizations and in regional conferences arranged by the Washington Business Group on Health and its Fortune 500 member-companies. The latter conference provided HCFA with the opportunity to explain the advantages to employers of using

coordinated care delivery systems in responding to the provisions of the Statement of Financial Accounting Standards (SFAS 106), which requires companies to project the long-term costs of their current retiree medical plans. Employers were also urged to consider coordinated care as a more efficient means of delivering health care to retirees.

CHAPTER IV

EFFICIENT OPERATION OF MEDICARE

INTRODUCTION

Medicare contractors fulfill the Federal Government's responsibility of paying Medicare beneficiaries and providers of services in a timely, accurate and fiscally responsible manner. Fiscal intermediaries (FIs) pay providers of services under Part A of the Medicare program, primarily for hospital inpatient activities. Their responsibilities encompass making and accounting for Medicare benefit payments, auditing the financial records of providers, making final settlement of cost reports, recovering any Medicare overpayments, and safeguarding the Medicare trust funds against payment for services that are not medically necessary.

Carriers adjudicate claims and make payments to beneficiaries and providers of services under Part B of the Medicare program, primarily for physician services. Their responsibilities include receiving and accounting for Medicare benefit claims, accounting for payments made directly to and/or on behalf of eligible Medicare beneficiaries, determining Medicare's payment amounts for medically necessary covered services, and computing and recovering overpayments in cases of erroneous payment. They also implement the participating physician program, establish methods to identify utilization patterns that deviate from medically accepted norms and report such deviations to the appropriate professional groups.

PHYSICIAN FEE SCHEDULE

A highlight of the fiscal year was the introduction on January 1, 1992, of a new Medicare physician payment system. It was the most significant change in the way Medicare pays doctors, practitioners and suppliers since the program began. Congress enacted a three-part physician payment reform package in 1989. One reform set a goal for the rate of increase in Medicare physician expenditures, while a second established limits on the amounts that physicians and suppliers who do not accept assignment can charge beneficiaries. The third major element established a physician fee schedule. The fee schedule is to be phased in over a five-year period. It replaces the historical customary, prevailing and reasonable charge system, which was criticized because it resulted in wide variations in payment levels for the same service in different geographic locations. The fee schedule is used to pay for physician services, services incident to physician services, outpatient physical therapy and outpatient occupational therapy services, diagnostic tests (other than clinical laboratory tests), and radiology services. The fee schedule applies when paying for these services regardless of

whether they are provided by a physician or a nonphysician (e.g., independently practicing physical therapists).

Essentially, the Medicare fee schedule amounts are based on the relative resources used to render a service--not the charges physicians have typically billed for the service. Variations in practice costs between areas are recognized through application of geographic practice cost indices. There are no payment differentials for a service based on the specialty of the rendering physician. There are annual updates to the fee schedule amounts.

Under the fee schedule, Medicare continues to pay 80 percent of the approved amount. The approved amount is the actual charge or the fee schedule amount, whichever is lower. The fee schedule amount for a service is the product of three numbers:

- The relative value units for the service. In almost all cases, this is established nationally for each procedure code and will not vary among carriers;
- The geographic practice cost indices for the locality where the service is rendered, and
- The national conversion factor used with the fee schedule. This is a single national number that is used by all carriers in calculating payments under the Medicare fee schedule.

The total relative value units (RVUs) for a service are the sum of the RVUs associated with three components of the service:

- The physician work required for the service. These units were developed by panels of physicians and researchers at Harvard University and, in some cases, refined by HCFA. The work component of the RVU was based on the time required to furnish the service, the intensity of the effort and the technical skills required;
- Practice expenses such as office rent, supplies and salaries of office staff, and
- Professional malpractice liability premiums.

Medicare fee schedule amounts are adjusted to reflect the variation in practice costs from area to area. A geographic practice cost index has been established for every Medicare payment locality for each of the three components of a procedure's RVU (work, overhead and malpractice).

About one-third of all physician services were paid on the basis of the full Medicare fee schedule for the portion of the

fiscal year beginning January 1, 1992, and ending September 30, 1992. The other two-thirds were paid on the basis of a transitional fee schedule while moving to the full fee schedule amount over the next five years. By 1996 all physician services will be paid under the full Medicare fee schedule. A service was paid at the full fee schedule amount in 1992 if the adjusted historical payment basis (AHPB) for the service was within 15 percent of the full fee schedule amount. (Generally, the AHPB was equal to the average Medicare allowance for the service in the locality in 1991, increased by the annual update factor for 1992. Then a 5.5 percent downward adjustment is applied. This reduction is a technical adjustment required to assure budget neutrality during the transition period. There is no permanent reduction in the fee schedule due to this adjustment.) This determination will be made for a service in each prevailing charge locality. Thus, a procedure might have been paid at the full fee schedule in 1992 in one locality but not in another.

If the AHPB in a locality exceeded or was less than the full fee schedule amount by more than 15 percent, the service is to be moved to the full fee schedule over a five-year period. For the subject period in FY 1992, if the AHPB was more than 115 percent of the fee schedule, 15 percent of the fee schedule amount was deducted from the AHPB; if the AHPB was less than 85 percent of the full fee schedule, 15 percent of the fee schedule amount was added to the APB. For years after 1992, the transition continues as follows:

- In 1993, 25 percent of the fee schedule amount is added to 75 percent of the 1992 payment rate.
- In 1994, 33 percent of the fee schedule amount is added to 67 percent of the 1993 payment rate.
- In 1995, 50 percent of the fee schedule amount is added to 50 percent of the 1994 payment rate.
- In 1996, all physicians' services will be paid on the full fee schedule.

MEDICARE CONTRACTORS

A variety of other program responsibilities were carried out by HCFA during the fiscal year, including contracting with 81 carriers and FIs, preparing budget statements and setting standards for Medicare contractors and monitoring their performance. The Agency also established procedures and instructions for all aspects of claims processing and bill payment, and implementing legislative changes. In overseeing contractor payment safeguard activities, HCFA developed a system for identifying employers and insurers responsible for making primary payments for medical costs under the Medicare as

Secondary Payer (MSP) provisions, performed intermediary and carrier medical reviews, and audited provider cost reports and overpayment collections.

During FY 1992, contractor administrative costs for processing 647.9 million claims and related activities totaled approximately $1.5 billion. Contractor budgets have become increasingly tighter in recent years as the volume of claims has soared 61 percent since FY 1987 while contractor budgets have increased only 40 percent. The real (after inflation) percentage growth in the contractor budget was even less.

MEDICARE CLAIMS

Medicare intermediaries received 101 million Part A claims in FY 1992 compared to 91.9 million in FY 1991, and Medicare carriers received 550 million Part B claims, an increase of 25 million over the FY 1991 figure. Both Part A and Part B Medicare contractors were generally successful in meeting the deadlines for the timely payment of Medicare claims. Contractors were required to pay at least 95 percent of all "clean" Medicare claims within 24 days. They were required to pay 95 percent of all claims within 60 days and 99 percent of all claims within 90 days. Claims submitted by physicians who signed agreements to participate in Medicare were to be paid within 17 days. The average cost of processing a Part A claim in FY 1992 was $2.80 while the average cost of processing a Part B claim was $1.71. Both figures were lower than the FY 1991 claims processing unit costs.

Approximately 84 percent of the Part A and 54 percent of the Part B claims were submitted via electronic media. The increased reliance on the electronic media for the submission of claims saved the HCFA approximately $36 million in FY 1992 based on the estimate that it costs 50 cents less to process an electronic media claim than a hard-copy claim. As part of the initiative to improve and speed the processing of claims, contractors significantly increased their outreach and support activities and their hardware capacity to accommodate higher percentages of electronic claims. Vendor fairs were sponsored with software companies to introduce providers to technological advances that contribute to greater use of electronic billing.

Additionally, funding was provided for electronic bulletin boards and E-Mail on a test basis, as well as for additional electronic data transmission lines and for bridge software to modify some existing provider software packages for electronic billing of Medicare. Medicare billing software was offered to providers free or at-cost to ease their conversion to electronic billing. Financial support also was provided by HCFA for development of software to enable claims data to be submitted via touch-tone telephone, for development of on-line claims status

inquiry modules, and for testing of the use of facsimile technology to enter data to Medicare claims processing systems. Additionally, provided money to intermediaries to convert their systems to issue electronic remittances in the American National Standards Institute (ANSI) 835 format and to represent Medicare interests in development and maintenance of ANSI standards.

MEDICARE TRANSACTION SYSTEM

In September 1992, HCFA published a Request for Proposal (RFP) for the design of a Medicare Transaction System (MTS). The MTS will be a single consolidated claims processing system which will replace the 15 systems now being used with one uniform system, integrating both Part A and Part B claims, to be operated at an optimal number of sites across the country. The MTS will operate in a totally automated environment. Generally, hospitals, physicians and other providers will transmit their electronic claims directly to an MTS operating site. Claims inputs and outputs will adhere to standard formats. Implementation of the MTS, which will be owned and managed by the Federal Government but will be developed, maintained and operated by private contractors, is currently projected for 1996.

Through economies of scale, the MTS will lower the overall cost of claims processing while improving service to both beneficiaries and providers. The costs of maintaining, enhancing and implementing changes to the claims processing system will be significantly reduced because changes will only have to be programmed once, rather than many times for many different systems. The design will be able to support a variety of transactions, permitting the use of alternative payment methods, and will establish integrated data bases that could support changes in benefit structure or administrative requirements. Once the MTS is in service, fiscal intermediaries and carriers will no longer be burdened with automated claims processing functions and will, therefore, be able to focus their resources on providing quality services to their Medicare customers.

QUALITY ASSURANCE

During the fiscal year, HCFA monitored and evaluated the performance of the Medicare contractors through the application of the national review system known as the Contractor Performance Evaluation Program (CPEP), which was streamlined in FY 1992 by significantly reducing the number of program standards. The CPEP for FIs consisted of 25 program standards grouped into four Part A functional areas, bill processing, payment safeguards, administrative management and program efficiency. Most FIs continued to display strong overall performance. As a whole, FIs achieved a 96.7 percent performance rating with four FIs failing the FY 1992 CPEP requirements. Various contract management actions were taken against the deficient FIs, including the

removal of the automatic renewal clause from their contracts. They also were required to establish corrective action plans to remedy their performance deficiencies.

The CPEP for carriers consisted of 27 program standards grouped into five Part B functional areas. As a group, carrier performance slipped from 95 percent in FY 1991 to 92.1 percent in FY 1992, with nine carriers failing the basic CPEP requirements. Contract management actions against seven of these carriers included the removal of the automatic renewal clause from their contracts. The deficient carriers also were required by HCFA to establish corrective action plans to remedy their performance deficiencies. One carrier's contract was not renewed.

Work continued during the fiscal year on the development of CPEP as a more effective evaluation program. Future CPEPs will require contractors not only to meet the basic requirements, but also to develop and implement innovative operational strategies. In a CPEP-related action, HCFA successfully developed and piloted a physician-satisfaction survey in FY 1992 to ascertain physician satisfaction with the performance of the Medicare carriers.

Work also continued during the fiscal year on several ongoing activities designed to improve the quality of Medicare contractor operations. For example, postpayment reviews were completed for a sample of claims processed by every carrier to identify and correct processing mistakes. In CY 1992, the national average carrier payment error rate decreased from 0.86 to 0.73. Similarly, for each fiscal intermediary, a sample of settled provider cost reports was reviewed to evaluate the quality of audits and settlements performed by the fiscal intermediaries. The sampled providers included Prospective Payment System (PPS) and non-PPS hospitals, home health agencies, and providers that had audits to establish the PPS capital payment rates. Nationally, approximately $20.5 million of erroneous payments were identified in 1992 through the audit quality review.

SAFEGUARDING THE TRUST FUNDS

HCFA and the Medicare contractors undertook many activities to safeguard the Medicare trust funds against inappropriate expenditures in FY 1992. Savings of over $5 billion were achieved, which resulted in a rate of return of more than $14 for each administrative dollar spent on payment safeguards (Table 3). While impressive, the $5-plus billion in savings are nearly 9 percent below FY 1991 levels. The decline in savings is attributable to funding constraints in provider audit and medical review and utilization review.

BENEFICIARY AND PROVIDER COMMUNICATIONS

The Explanation of Your Medicare Part B Benefits (EOMB) form was redesigned to improve and standardize communications with beneficiaries. EOMBs report a carrier's action on a claim to beneficiaries. The previous version had been criticized by beneficiary organizations as being too complex and hard to understand. Beneficiary focus groups were convened to provide input on how to simplify the EOMB's language and improve the presentation of the claims information. These comments were incorporated in the EOMB's redesign. The redesigned EOMB was tested by an outside contractor to determine beneficiary satisfaction with the new form. The new form was preferred by beneficiaries but some further changes were recommended. HCFA plans to implement most of the recommended changes.

Other activities undertaken during the fiscal year to better serve beneficiaries included decentralizing the process for correcting beneficiary entitlement records and the implementation with the Social Security Administration of a special project to identify and automatically enroll low-income Medicare beneficiaries who are eligible for State assistance in paying their Medicare cost-sharing amounts under the Qualified Medicare Beneficiaries (QMBs) program.

BENEFICIARY INQUIRY WORKLOADS AT CARRIERS AND INTERMEDIARIES

During FY 1992, Medicare intermediaries handled 1,885,844 beneficiary inquiries (1,576,712 telephone, 275,830 written, and 33,302 walk-in), and 2,391,744 inquiries from providers (1,778,725 telephone, 611,308 written, and 1,711 walk-in). The number of beneficiary inquiries increased 1 percent from the FY 1991 level.

Beneficiary inquiries to Medicare carriers increased 1 percent to 20,858,575 (19,061,780 telephone, 1,551,369 written, 245,426 walk-in). Carriers also handled 13,520,733 provider inquiries (9,710,498 telephone, 3,788,951 written, 21,284 walk-in). This represented a 23 percent increase in provider inquiries over the previous 12 months. Beneficiary and provider inquiries totaled 34,380,312.

Medicare carriers were reminded of the importance of the requirement that they provide beneficiaries with satisfactory local and toll-free telephone service. Carriers must meet busy signal and call acknowledgement standards for telephone service, and are required to electronically monitor telephone service performance. Monthly performance reports are required and if a carrier does not meet minimum standards, corrective action is taken by the appropriate HCFA regional office. During the fiscal year, carriers maintained an average 7.8 percent all-trunks-busy

(ATB) level of service in comparison with a standard of not more than 20 percent ATB.

MEDICARE AS SECONDARY PAYER (MSP)

Medicare may not pay primary benefits when payment for Medicare-covered services has been or can reasonably be expected to be made promptly under a workers' compensation law or plan of the United States or a State, or under a liability insurance policy or plan or under no-fault insurance. Also, under certain circumstances, Medicare may not pay primary benefits when payment for Medicare-covered services has been made or can reasonably be expected to be made by group health plans. However, Medicare sometimes mistakenly pays because it is unaware that the beneficiary has alternate primary coverage. In the case of group health plan coverage, substantial progress was made in FY 1992 in addressing this problem through the successful implementation of a legally mandated match of Internal Revenue Service, Social Security Administration and Medicare records. By the end of the fiscal year the match had been performed, beneficiaries and spouses with employment-related income had been identified, and a special contractor had issued surveys to identified employers for the purpose of verifying health coverage. In addition, HCFA developed plans to implement a questionnaire for verifying beneficiary health coverage at the time of initial enrollment.

MEDICARE TECHNICAL ADVISORY GROUP (M-TAG)

A special technical advisory group (TAG) comprised of HCFA staff, fiscal intermediaries and health care industry representatives began to meet on a regular basis in order to resolve numerous cross cutting issues. Their goal was to focus on issues pertaining to payment safeguards, credit balances and the claims payment processes, and to reach agreement on ways to improve these processes. Immediate improvements were made in the credit balance and payment safeguard areas through the issuance of revised program instructions.

MEDICAL REVIEW

A redesign of the carrier medical review (MR) process was implemented during the fiscal year with emphasis placed on contractor analysis of payment data for the purpose of identifying problem providers and subjecting them to medical reviews. Further refinements were made to a similar approach which was implemented the preceding year by FIs.

FRAUD AND ABUSE

Significant steps were taken during the fiscal year to strengthen HCFA's fraud detection and deterrence programs and to ensure that beneficiary complaints are responded to in a timely

and meaningful way. HCFA required its largest contractors to establish separate Medicare-dedicated fraud units during FY 1992, and commenced planning for cooperative fraud-detection efforts with the health insurance industry and various Federal, State, and public and private organizations committed to eliminating fraud. As part of the initiative, Medicare contractors were reminded of the importance of being responsive to beneficiary allegations of suspected fraud. The contractors were urged to expedite the handling of such cases and to work more closely with the Office of Inspector General in fraud investigations.

DURABLE MEDICAL EQUIPMENT (DME)

HCFA is preparing to award contracts for the selection of four regional Medicare carriers for the processing of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). These regional carriers will be referred to as durable medical equipment carriers or DMERCS. In addition, contracts will be awarded for the National Supplier Clearinghouse, which will assign identification numbers to all suppliers and the Statistical Analysis DMERC. The contracts are to be awarded in December 1992, and will take effect on January 1, 1993. After a 9-month transition phase, HCFA anticipates that the DMERCS will process their first claims on October 1, 1993. A Request for Proposal (RFP) for the Durable Medical Equipment regional carriers was released on May 14, 1992.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

During FY 1992, HCFA implemented section 4161(a) of OBRA-1990, which provided for Medicare coverage of Federally Qualified Health Center (FQHC) services effective October 1, 1991. Under Medicare, FQHCs located in medically underserved rural and urban areas or which serve a medically underserved population, provide primary care services, preventive services, primary preventive services covered under the Public Health Service Act and certain visiting nurse services. After publication of implementing regulations on June 12, 1992, HCFA did a mass mailing to qualified entities identified in HCFA and Public Health Service records, and by the end of the fiscal year enrolled 724 FQHCs.

AMBULATORY SURGICAL CENTERS

On July 1, 1992, Part I of the second national survey of Medicare participating ambulatory surgical centers (ASCs) was mailed to 1,400 facilities. The survey, which was sent in both hard copy and diskette format, requested data on surgical procedures performed, including type, volume and charges as well as financial information for the facility. Responses were received from nearly 80 percent of the facilities. Following verification, compilation and analysis of the data submitted for Part I, a subset of facilities will be asked to submit data in a

manner designed to establish the costs to a facility of performing designated high volume procedures. Audits of a subset of facilities' books and records will also be conducted. The first national survey of ASCs was conducted in 1986 when approximately 500 facilities were surveyed. Results of the current survey will be used in the annual update of ASC rates.

MEDICARE SUPPLEMENTAL INSURANCE (MEDIGAP) OPERATIONS

Medigap insurance is private insurance sold to individuals and groups and is designed to fill some of the gaps in Medicare coverage. Approximately 45 percent of Medicare beneficiaries have Medigap insurance. The Medigap program within HCFA became more complex because of provisions in OBRA-90 that mandated Federal standards for simplification and standardization of Medigap policies. Some of those changes were:

- Insurers must comply with the Medigap open enrollment period, preexisting condition requirements, Medicaid eligibility, non-duplication of coverage, and increased loss ratio requirements;
- Insurers are limited to offering up to 10 standardized Medigap plans;
- Medicare SELECT policies, Medigap policies with a coordinated care component, may be offered in 15 States designated by the Secretary; and
- Grants to States were authorized for the purpose of providing information, counseling and assistance related to buying adequate and appropriate health insurance by Medicare beneficiaries.

The Medigap provisions expanded the Federal role by requiring:

- States to submit their regulatory programs for mandatory Federal approval by July 30, 1992, or policies sold in those States must be certified directly by the Federal government;
- Enforcement of Federal standards by the States, including reports on loss ratios of Medigap policies, compliance mechanisms and consumer protection;
- The Secretary to review the States for compliance in enforcing the standards;
- Refunds of premiums by insurers where the loss ratios exceed the standards in the law; and

- Civil money penalties for insurers not complying with the provisions of the law.

Because of these changes, consumers who purchase insurance policies to supplement their Medicare benefits are facing less confusing choices and are assured of getting the benefits they want in a competitive market.

HCFA completed the initial review of State Medigap regulatory programs in FY 1992. All of the 55 jurisdictions, except for Montana, Oregon, Guam, American Samoa and the Commonwealth of the Northern Mariana Islands, submitted regulatory programs for HCFA's approval by July 30, 1992. Time extensions were granted to Montana and Oregon because State legislative approval of their respective regulatory programs was required and their legislatures did not meet in 1992.

HCFA began developing reporting systems to track loss ratio data and beneficiary complaints. The Agency established minimum data sets and a data dictionary for States to use in reporting Medigap complaints. The intent is to review the data on an ongoing basis to identify any unusual patterns of complaints attributable to insurance agents and companies. As required by OBRA 90, HCFA is taking a more aggressive approach toward Medigap oversight and will concentrate more on oversight in the future.

HCFA distributed grants totalling $10 million to virtually all States to develop or improve State beneficiary counseling programs. These programs will advise Medicare beneficiaries on a range of health insurance, including Medicare, Medicaid, Medigap, long term and other types of health insurance.

PAYMENT SAFEGUARD SAVINGS
(Dollars in Millions)

		FY 1988	FY 1989	FY 1990	FY 1991	FY 1992
MEDICARE SECONDARY PAYER						
	Funding	$ 68.5	$ 75.4	$ 63.5	$ 74.7	$ 90.2
	Savings	$1,878.2	$2,175.9	$2,483.6	$2,638.9	$2,809.8
Projected Rate of Return		16:1	19:1	25:1	38:1	36:1
Actual Rate of Return		27:1	29:1	39:1	35:1	31:1
MEDICAL UTILIZATION REVIEW						
	Funding	$ 123.5	$ 164.0	$ 146.7	$ 141.7	$ 116.2
	Savings	$ 866.5	$1,046.9	$1,139.8	$1,458.5	$1,151.8
Projected Rate of Return		7:1	7:1	6:1	6:1	6:1
Actual Rate of Return		7:1	6:1	8:1	10:1	10:1
AUDIT						
	Funding	$ 121.6	$ 136.9	$ 138.5	$ 144.3	$ 134.3
	Savings	$ 909.4	$ 820.0	$1,692.0	$1,698.0	$ 974.0
Projected Rate of Return		8:1	6:1	9:1	6:1	7:1
Actual Rate of Return		7:1	6:1	12:1	12:1	7:1
BENEFIT INTEGRITY						
	Funding					$ 10.0
	Savings					$ 80.0
Projected Rate of Return						8:1
Actual Rate of Return						8:1
TOTAL						
	Funding	$ 313.6	$ 376.3	$ 348.7	$ 360.7	$ 350.7
	Savings	$3,654.1	$4,042.8	$5,315.4	$5,795.4	$5,015.6
Projected Rate of Return		9:1	9:1	8:1	11:1	13:1
Actual Rate of Return		12:1	11:1	15:1	16:1	14:1

Chapter V

RESEARCH, DEMONSTRATIONS AND EVALUATIONS

INTRODUCTION

HCFA's Office of Research and Demonstrations (ORD) directed more than 350 research, demonstration and evaluation projects during FY 1992. Attention was focused on program expenditures as they relate to payment, coverage, eligibility and management alternatives under Medicare and Medicaid. Study activity also examined program impact on beneficiary health status, access to services, utilization and out-of-pocket expenditures. The behavior and economics of health care providers and the overall health care industry were also topics of investigation. These projects are used to assess new methods and approaches for providing quality health care while containing costs, and they often provide the basis for making critical policy decisions on health care financing issues.

Research, demonstration and evaluation activities pursued during the fiscal year included projects to test new reimbursement, coverage, eligibility and program management approaches, as well as research and evaluation studies of the impact of HCFA programs on health care costs, program expenditures, beneficiary access to quality health care services and the economics of the health care industry. HCFA is extensively involved in the creation of new and improved data sets to support these ongoing R&D activities. These projects result in knowledge about the basic structure, incentives, costs and effects of HCFA programs and policies and make it possible to refine existing policies, simulate or test various program changes on a trial basis, and develop innovative financing and delivery systems.

The ORD funded numerous new grants, contracts and cooperative agreements during the fiscal year. These projects are listed below under their respective program areas with the names of the awardees and amounts of money involved.

QUALITY OF CARE

A Comparison of the Accuracy of Several Screening Systems for Hospital Quality Assessment (Johns Hopkins University School of Medicine; $224,500) This study will compare several methods a hospital might use to screen and measure quality of care. The investigators will identify problems that are wrongly excluded or included by each method. Each method will be compared with implicit review by multiple reviewers and explicit criteria for certain conditions. The features of each system that lead to error, and others that should be added, will be determined. The

evaluation of the Uniform Clinical Data Set system, in terms of reproduceability, sensitivity, and predictive value, is one objective.

Validation of Nursing Home Quality Indicators (SysteMetrics/McGraw-Hill; $790,945) This project is a continuation of a recently completed cooperative agreement to investigate the usefulness of claims data from Medicaid and Medicare administration record systems as sources of nursing home quality of care (QCIs) measures. The previous study involved retrospective analysis of 1987 Medicaid and medicare claims data and facility deficiency data from two States. The goal of this project is to further the development of an automated quality assurance system using Medicare and medicaid claims data to provide continuous monitoring of the quality of care rendered to Medicaid recipients in long-term care facilities. The objective of this study is to validate the resident-level claims-based QCIs by: (1) recomputation of the claims-based indicators for one State using data from 1990 and 1991 (i.e., pre- and post-OBRA 1987), and an additional State for 1991; (2) physician and nurse examination of medical records for a sample of residents in a sample of nursing homes for the above States; and (3) establishment of the relationship of the QCIs to deficiencies cited and adverse outcomes.

PHYSICIAN AND AMBULATORY CARE PAYMENT SYSTEMS

Development of Hospital Medical Staff Volume Performance Standards (The Urban Institute; $616,002) This project is an extension of a prior study that explored the hospital medical staff as a potential risk pool for setting separate medicare volume performance standards (MVPS) as an alternative to the national standards mandated under the Omnibus Budget Reconciliation Act of 1989. This study seeks to provide the several additional analyses that would be necessary to implement such an MVPS. The four major initiatives are: 1)developing a case-mix index based on hospital diagnostic-related groups (DRGs) using the FY 1990 DRG grouper and Medicare Fee Schedule 1992 relative value units (RVUs) rather than allowed charges; 2) analyzing the stability of case-mix-adjusted RVUs per admission across hospital staffs and over time using a file of 100-percent admissions and all associated physician charges for a five-percent sample of hospitals in a representative group of States; 3)developing physician profiling for hospital episodes and analyzing the potential effect of certain medical staff characteristics on this type of MVPS; and 4) investigating the relationship between Part B physician costs and Part A hospital costs.

Medicare Volume Performance Standards for Voluntary Physician Organizations (Brandeis University; $846,356) This project is an extension of a prior study that explored the potential for

establishing separate volume performance standards for qualified physician organizations whose experience would be measured directly, rather than implied by the national Medicare volume performance standards (MVPS) specified by the Omnibus Reconciliation Act of 1989. This study seeks to design a program in which physician practices in the fee-for-service sector could volunteer to operate under such MVPSs. The major initiatives include: (1) defining the volume and intensity (VI) measures and standards at the practice level; (2) developing criteria and incentives for physician practice MVPS participation; (3) determining the administrative requirements; and (4) analyzing the administrative, economic, and clinical contexts of physician practices in which such MVPSs would be implemented. Guidelines will be developed for physician practices to operate under their own MVPSs consistent with principles of efficiency and safe guarding quality care. Additionally, the alternative outcomes of physician practice MVPS participation will be simulated.

Geographic Practice Cost Index Assessment and Update (Health Economic Research, Inc.; $582,885) A major change in Medicare physician payment rules encompassing three major elements--replacement of the reasonable charge payment mechanism with a fee schedule for physician services, replacement of the maximum allowable charge limit with new limiting charges, and establishment of national volume performance standards--was implemented on January 1, 1992. The fee schedule, composed of national uniform relative values for physician services, must be adjusted for the cost of medical practice in each medicare payment locality. That geographic adjustment factor is termed Medicare Geographic Practice Cost Index (GPCI). The purpose of this project is to assess the GPCI, as published in Addendum C of 56 Federal Register 59,785 and update the work, practice expense, and malpractice expense component indexes with 1990 Census and other more recent data. The assessment process will address methodological limitations, proxy data, and new data sources. Weights for the various work, practice expense,and malpractice expense components of the index will be updated with the latest available data. Methodologies will be developed that might be used in future updates of the GPCI.

Medicare Fee Schedule Refinement (Harvard School of Public Health; $585,922) This contract has the following tasks:

- To validate specialty-specific examples for evaluation and management services that are included in the Medicare fee schedule (MFA) but are performed by specialties that are not included under the umbrella of the American Medical Association.

- To determine relative work values for specific psychological tests.

- To validate time components of work for reference procedures of the MFS.

- To develop relative work values for procedures that were identified in the MFS as being paid "By Report."

- To determine the magnitude of economies of scope in the provision of bilateral and surgical procedures.

Reasonable Charge Impact Studies (HK Research Corporation; $150,000) This project is a continuation of work on physician payment that was performed under a previous cooperative agreement. Its purpose is to collect the current reasonable charge pricing, volume (claims), and provider characteristics data files, to standardize the data to enhance its comparability between carriers, and to perform descriptive analyses that update and enhance the descriptive studies performed under the earlier project.

Bundling Physician Services (Health Economics Research, Inc.; $302,330) The purpose of this project is to examine bundling various types of ancillary medical services that are performed in various settings. It involves analysis of such issues as bundling into physician visit payments or making payments as an add on to the visit. Bundling of services could create incentives for appropriate utilization of services within the package and is a potential mechanism to influence growth in the volume of services provided. The emphasis of the analysis is on the kinds of ancillary services provided in conjunction with physician office visits for Medicare beneficiaries. The contractor will perform five analytic subtasks: (1) a descriptive analysis of all of the kinds of ancillary services provided in conjunction with physician office visits with particular emphasis on high-volume service; (2) a paper describing criteria that could be used for bundling ancillary services into physician visits in various settings and discussing the conceptual and technical issues in bundling various kinds of ancillary services; (3) an analysis of redistributional effects among different specialties of bundling various kinds of ancillary services into physician fees and the effects of add on payment policies; (4) an examination of what the bundle of ancillary tests would look like if the ambulatory patient group bundling algorithm were used to pay for tests in physician offices, including a descriptive analysis and a redistribution analysis; and (5) an examination of the adequacy and consistency of the National Claims History (NCH) file, particularly unique physician identifiers and diagnosis codes from all relevant settings, if the NCH data were to be used to determine aggregate bundles for payment (e.g., an episode of illness).

CAPITATED PAYMENT SYSTEMS

Effect of Market Structure on Health Maintenance Organization Financial Performance (Carnegie mellon University; $171,860) The HMO industry has expanded substantially over the past 10 years. This has led to substantially more competitive local HMO markets and a significant change in HMO demographics, with IPAs now the most prevalent HMO type. A correlate of these competitive changes is the increasingly restrictive State financial regulations. Research on HMO premiums and costs has not focused on the effects of these substantially different environments, thus little is known about the effects of market structure and State regulations on HMO premiums and costs. The purposes of this study are to: (1) determine if competition among HMOs can result in beneficial effects for health care consumers through lower premiums and costs; (2) estimate the financial effects of some specific State regulations on premiums and costs; and (3) estimate the impact of competition and regulation on the marginal costs of providing health care to individuals under and over age 65. The investigators will examine these questions for all HMOs operating in the period of 1988 to 1991 using data from financial statements filed by HMOs with State regulators and using measures of market structure developed in previous research.

Demonstration Project to Case Manage Medicare Beneficiaries with Catastrophic and Chronic Conditions Residing in the State of Indiana (AdminaStar Solutions; $521,644) The demonstration is designed to evaluate the appropriateness of providing case management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. AdminaStar will provide case management services to patients with congestive heart failure.

Iowa Foundation for Medical Care Case Management Demonstration (Iowa Foundation for Medical Care; $355,250) The demonstration is designed to evaluate the appropriateness of providing case management services for Medicare beneficiaries with catastrophic illnesses and high medical costs. The Iowa foundation for Medical Care will provide case management services to patients with one or two chronic conditions, chronic obstructive pulmonary disease and congestive heart failure. These conditions are diseases with known treatment variability and frequent rehospitalizations.

Case Management of Elderly at Risk for Acute Hospitalization (Providence Hospital; $459,744) The demonstration is designed to evaluate the appropriateness of providing case management services for medicare beneficiaries with catastrophic illnesses and high medical costs. Providence Hospital will provide case management services to patients with a number of diagnoses associated with high rates of hospitalization.

Actuarial Methods for Improving Health Care Financing Administration Payment to Risk Health Maintenance Organizations (Actuarial Research Corporation; $449,510) This project will assess four alternatives to the adjusted average per capita cost (AAPCC) method for paying Medicare HMOs. They are:

- Partial capitation: Some services are paid on a prospective capitation basis and others retrospectively on a cost basis.
- Reinsurance with Medicare as the reinsurer.
- Prospective experience rating in which a prospective payment will be made on the basis of past experience.
- Select and ultimate rates: This method takes into account initial favorable selection with an adjustment for regression to the mean over time.

Analysis of Social Health Maintenance Organization Data to Support Research Regarding Health Maintenance Organizations, Tax Equity and Fiscal Responsibility Act Health Maintenance Organizations, and Long-Term Care Issues (University of Minnesota; $24,963) The purpose of this project is to analyze the social health maintenance organization (S/HMO) data to determine the capacity to support research regarding (1) HMO issues (e.g., cost-effectiveness of coordinated care relative to the fee-for-service (FFS) system, differences in access to and use of various services such as use of expensive technologies and provision of preventive services in HMOs relative to the FFS system); (2) TEFRA HMO issues (e.g., what is the effect of the phenomenon of "aging in place"); and (3) long-term care issues (e.g., how does provision of expanded chronic care services influence acute care service use?).

Special Care Managed-Care Initiative (Wisconsin Department of Health and Social Services; $656,270) The purpose of this project is to gain improved understanding of the need, utilization, and cost of delivery of health services to high risk, severely disabled persons. The severely disabled population is a significant user of medical services. Moreover, costs since 1988 have increased at a rate double the rate of population increase. Therefore, an important objective is to contain the cost and utilization of Medicaid services of the severely disabled while maintaining or improving the level of client satisfaction. Special Care, Inc. (SCI), is an independent, nonprofit organization that represents a joint venture between the Milwaukee Center for Independence, a rehabilitation facility, and the Wisconsin Health Organization, an established HMO. SCI will create specialized services, including a dedicated physician's panel, case management services, and clinical services as strategies to assess medical need and to better coordinate

service resources available in the community. The State of Wisconsin will use a capitation methodology for reimbursement of SCI Enrollment of SCI members will be voluntary.

HOSPITAL PAYMENT

Effects of Prospective Payment System Payment Policies for Transfer Cases and Outlier Cases (RAND Corporation;$203,878) This project is to assess current payment policies for hospital transfer and outlier cases and, where appropriate, to make recommendations for potential policy changes. The project will model the resources used by hospitals for existing transfer cases and transfer-related cases for which some special payment might be appropriate. Alternate transfer payment options will be formulated and examined in simulations. The project will also examine the effect of current hospital outlier policy on hospital charging behavior and on patterns of length of stay. Potential changes in outlier policies will also be simulated.

Data for Hospital Cost Monitoring and Analysis of Hospital Costs (American Hospital Association; $715,700) HCFA will receive from the American Hospital Association (AHA) the output from its National Hospital Panel Survey and Annual Survey of Hospitals for fiscal years 1992-96. These data will serve as a prime source of outside data on the performance of hospitals and will be used in HCFA analyses, research, and publications.

Alternative Service Limitations for Limited Service Hospital Models (University of Minnesota Research Center; $59,827) This study examines the advantages and disadvantages of alternative service limitations that could be used to define substitutes for the rural hospital. Since many rural hospitals have been unable to respond to financial pressures in recent years and have been closing, there has been interest in developing alternative models to the traditional acute care facility. The researchers will review the literature and examine models being tried around the country. An advisory panel will be convened to develop new ideas as well. Medicare data will be examined to determine the characteristics of the cases now being treated in rural hospitals.

Research Plan for Hospital Payment Policy Interactions (Center for Health Policy Studies; $166,687) This project is developing a research plan to study interactions in Medicare hospital payment policy. It is possible that policy interactions among Medicare payment methods for different services and settings may create undesirable incentives. Medicare policy is typically segmented by service, and elements that are common across payment policies (such as adjustment for labor costs) may be applied differently across services or settings. Behavioral interactions may also exist. That is, changes in payment policy for one service or setting can have impacts on another service or setting. This

project has five parts: (1) health systems overview, in which a conceptual approach to researching hospital policy interaction issues is developed; (2) research strategy, where policy and behavioral interactions are put into an analytical framework to address research questions more precisely; (3) literature review; (4) research agenda; and (5) data base planning.

Measurement of Outpatient Facility Resource Costs (Center for Health Policy Studies; $550,112) The implementation of an outpatient prospective payment system by HCFA will require a thorough knowledge of costs of outpatient services. The primary purpose of this study is to prepare a national data base of outpatient facility resource costs that can be used as input to formulate an outpatient prospective payment system (PPS). Implementation of an outpatient PPS system requires thorough knowledge of the costs of outpatient services so that payment rates reflect resource use. To meet the need for more accurate resource measures, this study will measure resource use and resource costs for a variety of outpatient procedures and visits. The study may then be used to asses equity and adequacy of relative weights for an outpatient PPS system. The approach of the study is to focus on the resource costs of procedures as they are categorized in the ambulatory patient group (APG) patient classification system. All APG categories are being studied, including surgery, medical diagnoses and ancillary tests. The study will only analyze facility costs and will not consider physician costs. In addition to providing procedure/service-specific resource costs for a large number of procedures/services, this study will:

- Identify direct and indirect costs by type for each procedure/service.
- Identify differences in resource use and unit costs on a procedure/service-specific basis across settings, i.e., hospital OPDs, ASCs, and physicians' offices.
- Identify marginal costs of procedures when two or more procedures are performed at the same time.
- Compare procedure/service-specific resource costs to other procedure/service-specific values including charges and current payment levels.
- Compare aggregate resource costs to aggregate outpatient costs reported in Medicare cost reports and other sources of cost data.

PROGRAM EFFICIENCIES, ANALYSES AND REFINEMENTS

Impact of Complicating Diseases on End-Stage Renal Disease (ESRD) Outcomes and Costs (The Johns Hopkins University School of

Medicine, $321,044) The purpose of this project is to examine patient and provider characteristics associated with complicating diseases within the ESRD population, and the effects of these disease patterns on patient outcomes, utilization, and costs. The study design will involve longitudinal analyses of ESRD patients to determine risk factors associated with the onset of complicating illness and outcomes such as hospitalization and mortality. The study period covers the years 1984-1990 and will draw upon the ESRD Program Management and Medical Information System and other Medicare statistical files.

Evaluation of Capitation Payment for End-Stage Renal Disease Services (RAND Corporation, $239,056) The purpose of this project is to develop alternatives to capitating payments for services to ESRD patients and to perform a preliminary evaluation of the financial implications of at least one such payment system on the Medicare ESRD program and on the health plan serving ESRD patients. The work will address several considerations that are central to the design of a capitation payment system for ESRD services. These include incentives for appropriate service use, control of program costs, and patient and provider participation; selection of services to be included in the capitation; and methods to adjust capitation payments for financial risks.

Cost-Containment Measures for Physician and Other Services (Mathematica Policy Research, Inc.; $71,957) This study will review existing literature on programs for ambulatory surgery, preadmission testing and same day surgery, and conduct a survey of State Medicaid programs concerning the States' use of these services as cost-containment measures.

Medicare Ambulatory and Coordinated Care Demonstration Projects: Master Contracts (Mathematica Policy Research, Inc., Lewin/ICF, Health Economics Research, Inc., and Abt Associates, Inc.; $151,738) HCFA awarded master contracts to four firms to assist HCFA in designing, implementing, and/or evaluating Medicare ambulatory and coordinated care demonstrations projects. They will be used for congressional and administration priorities that need to be awarded within short timeframes. The four contractors will have the opportunity to compete for each individual delivery order.

Medicare Institutional/Facility-Based Services Demonstration Projects: Master Contracts (University of Colorado, Mathematica Policy Research, Inc., and University of Minnesota; $143,402) The purpose of this master contract is to assist HCFA in developing, conducting, and evaluating high priority demonstration projects designed to obtain information in a timely manner for program and policy considerations. These demonstration projects are for medicare services based in, or closely associated with, health care institutions or facilities. The services to be studied may include inpatient services such as acute medical/surgical care,

extended care, and long-term care. Outpatient facility services may include ambulatory surgery, kidney dialysis, and medical visits. These services are provided in such facilities as hospitals, hospital outpatient departments, rural primary care hospitals, skilled nursing facilities, nursing homes, ambulatory surgery centers, and kidney dialysis facilities.

Support to the National Science Foundation, Committee on National Statistics (National Science Foundation; $30,000) The HCFA Office of Research and Demonstrations will transfer $30,000 to the National Science Foundation for core support for the Committee on National Statistics. The Committee is composed of distinguished statisticians who work to improve the statistical methods and statistical information on which public decisions are based. The Committee performs program development tasks to establish major separately funded special projects as well as smaller or more general studies, reviews, and conferences that are supported entirely by core funding.

HEALTH CARE PREVENTION AND ACCESS

Access to Medicare Physician Services (Urban Institute; $464,055) Changes in Medicare policy such as the Medicare fee schedule can have crucial impact on access. This project will address various aspects of access to Medicare physician services. One task will measure price and volume/intensity change over the period 1985-1990 for disaggregated types of service. A second task will examine the effect of changes in the prices paid for physician services on access to services. The final task will use the 1992 Medicare Current Beneficiary Survey to study beneficiary access to physician services.

Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program (People-to-People Health Foundation, Inc.; $334,040) The Medicaid program is required to cover the Medicare premiums, deductibles, and copayments for low-income elderly beneficiaries meeting certain income and asset criteria. Currently, it is estimated that half of the poor elderly Americans potentially eligible for Medicare buy-in benefits are not enrolled in the program. Project HOPE will conduct a multidimensional, two-year research project, using data from the HCFA Current Beneficiary Survey and the 1990 Population Census, in order to understand the magnitude of enrollment and nonenrollment in the Qualified Medicare Beneficiary buy-in benefit. The project will: (1) produce national estimates of the size and characteristics of the elderly populations enrolled in the QMB program; (2) identify the most significant barriers to program participation and the most frequent sources of information that would facilitate outreach; and (3) identify local areas where nonenrollees are most likely to reside and where outreach programs tailored to the needs and preferences of different subpopulations of poor elderly would be effective.

Impact of the Medicare Fee Schedule on Access to Physician Services (Center for Health Economics Research; $768,498) The purpose of this project is to evaluate the impact of the medicare fee schedule (MFS) on access to care. A sample of geographic areas will be selected for study based on the size of the payment change under the MFS. Access will be measured both in terms of utilization and outcomes, as well as financial liability. National trend data will also be developed. Changes in regular source of care and difficulties obtaining care will be assessed using the Medicare Current Beneficiary Survey.

Economic Barriers to Access to Health Care Among The Elderly (RAND Corporation; $562,453) The purpose of this project is to determine the degree to which economic barriers to health care exist within the elderly population. The study will identify socioeconomic subgroups among the elderly that may be more or less vulnerable to health services access problems, and will study the relationship of health services utilization to economic status, insurance status, household structure, and sources of social support. Analyses will be performed using a data base that links Medicare administrative records with the 1990 Health Supplement to the Panel Study of Income Dynamics (PSID).

SUBACUTE AND LONG-TERM CARE

Community Nursing Organizations Demonstration (Carle Clinic Association, Carondelet Health Services, Inc., Living at Home/Block Nurse Program/Metropolitan Visiting Nurse Association, and Visiting Nurse Service of New York; contract) Section 4079 of Public Law 100-203 directs the Secretary to conduct demonstration projects at four or more sites testing payment under the Medicare program for services furnished to Medicare beneficiaries by community nursing organizations (CNOs). The demonstration will test the feasibility and effect on patient care of a capitated, nurse-directed service delivery model. Urban and rural sites as well as different kinds of organizations (such as home health agencies and health maintenance organizations) will participate. The model will cover a Medicare services package that includes home health care, durable medical equipment, and certain ambulatory care. The CNO sites may also provide other optional community services to enrollees. Awardees will have a one-year developmental period to establish detailed operating plans and protocols. At the end of the developmental year, if the developmental period has proceeded as scheduled, HCFA will then enter into an agreement with the individual organizations to begin a three-year operational period as CNO sites.

Evaluation of the Community Nursing Organizations Demonstration (Abt Associates, Inc.; $262,433) Section 4079 of Public Law 100-203 directs the Secretary to conduct demonstration projects at four or more sites testing payment under the Medicare program for services furnished to Medicare beneficiaries by community nursing

organizations (CNOs). The demonstration will test the feasibility and effect on patient care of a capitated, nurse-directed service delivery model. The evaluation of the CNO demonstration is a two-tiered study. The first tier will focus on operational feasibility of the CNO model, relying primarily on process analyses and case studies. The evaluator will also develop an evaluation strategy for a possible second tier study to evaluate patient-level impacts on such measures as mortality, hospitalization, physician visits, nursing home admissions, and Medicare expenditures. The second tier evaluation will only be carried out if the number of sites and CNO enrollees are sufficient to evaluate patient-level impacts.

Long-Term Care Program and Market Characteristics ($605,103) This project will collect data on and study the effects of nursing home and home health care characteristics and markets for Medicare and Medicaid services in 50 States. Primary and secondary data for the 1990-93 period will be collected to update earlier data collected in previous studies for the 1978-89 period. A comprehensive survey will collect data on licensed nursing home bed supply and occupancy rates, State certificate of need programs, State preadmission screening programs, and Medicaid nursing home and home health reimbursement. A special analysis will provide detail on each State's current methodology for determining nursing home capital costs, the impact of proposed case-mix reimbursement on operating income, reimbursement methodology for freestanding subacute services/units, and Medicaid methodology used to reimburse for care in board and care homes, geriatric day care centers, and ICF-MR facilities. A public use data base will be prepared to provide a complete set of data for the period 1978-1993.

A Randomized Controlled Trial of Expanded Medical Care in Nursing Homes for Acute Care Episodes (Monroe Country Long-Term Care Program, Inc.; $269,543) The objective of this demonstration is to develop, implement, and evaluate the effectiveness of expanded medical services to nursing home residents who are undergoing acute illnesses, or deterioration in chronic illnesses, which would ordinarily require acute hospitalization. The intervention will include many services that are available in acute hospitals and are feasible and safe in nursing homes. These include an initial physician visit, all necessary followup visits, diagnostic and therapeutic services, and additional nursing care including private duty if necessary. The major goals of the demonstration are to reduce medical complications and dislocation trauma resulting from hospitalization, and to save the expense of hospital care when a patient could be managed safely in the nursing home with expanded services.

Chapter VI

PROMOTING IMPROVEMENTS IN HCFA

INTRODUCTION

In FY 1992, HCFA had 4,100 employees working at its central office in Baltimore, Maryland, executive offices in Washington, D.C., and 10 regional offices. Their varied assignments included policy development, program operations, legislative analysis and liaison activities, health care research and demonstrations, budget preparation and analysis, actuarial studies, data collection and processing, enforcing health care quality standards, and public information activities. These activities are overseen by an administrator who is assisted by a deputy administrator and associate administrators for management, operations, program development, and communications. The regional offices, which are managed by regional administrators, are located in Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, New York, Philadelphia, Seattle and San Francisco. The 1,500 employees in HCFA's regional offices perform most of the agency's frontline operations and serve as primary points of contact for program beneficiaries, contractors, State agencies and the public.

PROCUREMENT GOALS

HCFA pursued HHS procurement preference and competition goals in the awarding of more than $80.6 billion in contracts during the fiscal year. A summary of the goals and HCFA's actual performance in each of seven procurement categories is as follows:

	Category	Goal	Actual	Total Dollars
1.	Small Business	41.3%	35.4%	$35,777,536
2.	Sm. Bus. Set Asides	10.0%	17.8%	17,957,029
3.	8(a)	18.8%	14.6%	14,757,576
4.	*Direct Minority	2.4%	1.7%	1,774,023
5.	Women-owned Business	6.5%	4.9%	4,930,999
6.	Labor Surplus Area	1.6%	5.3%	5,409,331
7.	Competitive	80.0%	87.3%	79,695,492

* Because there is no mandated set-aside for direct awards to minority firms, achievement of this goal was primarily dependent upon the minority vendors submitting proposals for and winning competitively bid contracts.

OFFICE AUTOMATION

Recognizing that the health care and management data systems of the future--standard, integrated, flexible, and powerful--will

provide a foundation for improved medical care, HCFA made significant strides during the fiscal year towards an entirely electronic medical record and transaction processing system. The Agency's Comprehensive Personnel System also was improved during the fiscal year through the implementation of program controls to prevent input errors and the updating of the subsystems to reflect revised processing procedures. Work also continued on a detailed analysis of long-range systems requirements as part of an overall systems modernization initiative.

In conjunction with the improvements to the automated systems, HCFA employees were provided with a variety of computer training courses, including instruction in wordprocessing, and spreadsheet and database applications on personal computers. The increased use of automation has promoted efficiency in the personnel operations of the Agency.

RECRUITMENT INITIATIVES

In an effort to meet the increased need to recruit and retain qualified personnel, HCFA continued efforts to strengthen its recruitment programs. Several new recruitment authorities were obtained from the Office of Personnel Management (OPM), including Delegated Examining Authority and the Professional and Administrative Career Schedule B Authority. These authorities should provide managers with increased hiring flexibility and are expected to expedite the recruiting process. HCFA continued to expand its Cooperative Education Program and focused on methods of attracting health care curriculum graduates and minority students. In this regard, the Agency conducted a comprehensive program in support of the Office of Personnel Management's Presidential Management Intern Program (PMI). Twenty-one interns at HCFA were provided mentors, individual developments plans, training, seminar services and rotational assignments. The PMI program provides an excellent source for recruiting high calibre individuals with potential to assume management positions.

EQUAL EMPLOYMENT OPPORTUNITY ACCOMPLISHMENTS

HCFA's workforce increased by 185 during the fiscal year to 4,100, of which 3,977 were in the General Schedule (GS), General Merit (GM), and Senior Executive Service (SES) categories. The percentage of minorities in the GS/GM 13-15 grade band remained at 12.6 percent, the same as FY 1991, while the percentage of non-minority women in the GS/GM 13-15 grade band increased from 26.7 percent to 29.1 percent.

Of the 11 transitional positions maintained by the Agency in FY 1992, 6 or 55 percent, were assigned to minorities and 10 to severely handicapped individuals. Transitional positions are intended to prepare lower-graded staff for movement into higher positions through formal training and job experience.

The number of GS and GM positions in the 13 to 15 grade band increased during the fiscal year from 1,658 to 1,741, and the number of minorities in these positions rose from 210 to 220. The number of Black females in the GS/GM 13-15 grade band rose from 98 to 100, and the number of white females increased from 443 to 506. There was a decrease from 12 to 10 in the number of Asian-American females in this grade band.

EQUAL EMPLOYMENT OPPORTUNITY ACCOMPLISHMENTS

	FY 1991	%	FY 1992	%
HCFA Workforce	3,915		3,977	
GS/GM 13-15 Grade Band	1,658		1,741	
Minorities	210	12.6	220	12.6
Non-Minority Females	443	26.7	506	29.1
Transitional Positions	15		11	
Minorities	9	60.0	6	55.0
Employees with targeted Disabilities	45	1.1	55	1.4*

*(Percent of HCFA workforce)

CHAPTER VII

REPORTS AND PUBLICATIONS

INTRODUCTION

HCFA publishes a variety of reports and publications dealing with the Medicare program. Except where noted, single copies of the beneficiary publications listed in this section are usually available from local Social Security Administration offices during the year of issuance or by writing to:

Health Care Financing Administration
Office of Public Affairs (OPA)
Room 403-B Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Placement on the mailing list for notification of all research and demonstration (R&D) reports as they are published and for single complimentary copies of publications, with the exception of the HCF Review, are available by written request from:

Health Care Financing Administration
Office of Research and Demonstrations (ORD)
Executive Secretariat
Room 2230 Oak Meadows Building
6325 Security Boulevard
Baltimore, Maryland 21207

BENEFICIARY PUBLICATIONS

The Medicare 1992 Handbook (HCFA 10050 1992). A comprehensive explanation of the Medicare program for Medicare beneficiaries.

Medicare and Advance Directives (HCFA 02175 1992) A leaflet that explains a Medicare beneficiary's right to prepare an advance directive describing the types of care the beneficiary does or does not want in the event the beneficiary loses the ability to make or communicate those decisions.

Medicare Savings for Qualified Beneficiaries (HCFA 02184 1992) A leaflet that explains State financial assistance available to help pay Medicare's cost-sharing amounts for certain individuals whose income is at or below the national poverty level.

Medicare and Your Physician's Bill (HCFA 02176 1992) A leaflet that explains how Medicare pays for physician services received by beneficiaries, and how Medicare determines how much it will pay for a covered-service.

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (HCFA 10128, 1992) A booklet that describes Medicare coverage for end-stage kidney disease patients.

Medicare and Other Health Benefits: Who Pays First? (HCFA 02179, 1992) A leaflet that explains the Medicare Secondary Payer provisions to beneficiaries. It also explains where beneficiaries can go for information regarding who should be the primary payer on their health insurance claims when they have other insurance.

Your Hospital Stay Under Medicare's Prospective Payment System (PPS) (HCFA 02163, 1989) A pamphlet that describes the PPS, diagnosis related groups and Peer Review Organizations.

Hospice Benefits Under Medicare (HCFA 02154, 1992) A pamphlet that describes the special rules of coverage for care in a hospice program.

Guide to Health Insurance for People with Medicare (HCFA 02110, 1992) A booklet that discusses what Medicare pays and does not pay, types of private health insurance available to supplement Medicare, and what to look for when shopping for private health insurance.

Guide to Choosing a Nursing Home (HCFA 02174, 1991) A booklet that explains what to look for when selecting a nursing home.

Medicare and Employer Health Plans (HCFA 02150, 1991) A pamphlet that explains the law requiring employers to offer employed Medicare beneficiaries age 65 or older the same health insurance plan that they offer to their younger employees.

Medicare and Coordinated Care Plans (HCFA 02195, 1992) A leaflet that describes Medicare benefits available through health maintenance organizations and other coordinated care plans.

Medicare Q & A (HCFA 02172, 1991) A booklet that provides answers to 60 commonly asked questions about Medicare.

Medicare Coordinated Care Q&A (HCFA unnumbered 1992) A booklet that answers to 27 commonly asked questions about Medicare and coordinated care plans that serve Medicare beneficiaries.

Medicare Coordinated Care Directory (HCFA unnumbered, 1992) A booklet that lists all of the coordinated care plans with Federal contracts or agreements to participate in the Medicare program.

Medicare Coverage for Second Surgical Opinions (HCFA 02173, 1991) A leaflet that discusses the advisability of and procedure for obtaining a second medical opinion before agreeing to non-emergency surgery.

Medicare Secondary Payer (HCFA 02193, 1991) A booklet for employers that explains how Medicare is secondary payer for Medicare-eligible employees who are covered by employer health plans.

HCFA also acquired and distributed during 1992 a number of Medicare-related booklets published by commercial publishers in cartoon format primarily for audiences with low literacy levels. These booklets included:

Medicare and You (Unnumbered, 1991) Cartoon booklet explaining what Medicare is, what it covers and pays, and how to qualify for Medicare.

Medicare and Medicaid (There is a Difference!) (Unnumbered, 1992) Cartoon booklet that explains the differences between Medicare and Medicaid.

REPORTS

HCFA FINANCIAL REPORT:Fiscal Year 1992 The Chief Financial Officers Act (CFOA) of 1990 was implemented to improve the financial management and accountability of U.S. Government agencies based upon the best practices of American business and industry. One of its provisions requires that all major agencies publish annual financial statements and an accompanying report. HCFA published its initial "Financial Report" as required by CFOA for FY 1992. The report reflects HCFA's strong support and backing of the requirements of the CFOA and represents an important first effort in financial reporting.

Medicare Hospital Mortality Information (HCFA 1992) The fifth annual report of hospital mortality rates for Medicare patients at 6,000 acute care hospitals for the years 1988 through 1990. The report comprises 24 volumes and a technical supplement.

National Listing of Medicare Providers Furnishing Kidney Dialysis and Transplant Services (HCFA 03318) Self-explanatory.

HCFA's Office of Research and Demonstrations publishes a variety of reports and publications covering research and demonstration activities and statistical information on the Medicare and Medicaid programs. These include:

Status Report: Research and Demonstrations in Health Care Financing. Provide basic information in a brief format on the approximately 300 intramural and extramural projects conducted by HCFA/ORD to examine program expenditures as they relate to reimbursement, coverage, eligibility and management alternatives under Medicare and Medicaid.

Health Care Financing Review (Quarterly Journal Plus Annual Supplement). HCFA's quarterly research journal reports findings related to health care financing and delivery, includes trends data that highlight economic developments in the health care sector, and announcements of new HCFA research publications and projects. The HCF Review is available on a subscription basis ($19.00 per year) from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Additional information on the research publications program and the availability of various reports may be obtained from the ORD Publications and Information Resources Branch, Room 1-A-9 Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Final reports from completed extramural projects funded by HCFA are available for a fee by writing or phoning:

National Technical Information Services (NTIS)
Document Sales
5285 Port Royal Road
Springfield, Virginia 22161
Telephone (703) 487-4650 (Document Sales)
(703) 487-5600 (General Information)

CHAPTER VIII

REGULATIONS PUBLISHED IN FY 1992

Listed below are the various proposed and final regulations and other documents affecting the Medicare program published in the Federal Register during FY 1992. The date of publication appears in the column on the left and the page at which the item was printed is shown at the end of the title.

Date	Title
10/03/91	Medicare and Medicaid Programs; Eligibility for premium Hospital Insurance; State buy-in agreements (pg. 50058).
10/07/91	Confined to the home requirements for home health services (pg. 50542).
10/09/91	Clarification of Medicare's accrual basis of accounting policy (pg. 50834).
10/09/91	Continuous use of durable medical equipment (pg. 50821).
10/11/91	Conditions of participation for home health agencies (pg. 51334).
10/17/91	Prepaid Health Care: Obsolete Provisions (pg. 51984).
10/22/91	Swing-Bed Program changes (pg. 54539).
10/25/91	Essential access community hospitals (EACHs) and rural primary care hospitals (RPCHs) (pg. 55382).
11/05/91	Criteria and standards for evaluating intermediary and carrier performance; correction (pg. 56544).
11/06/91	Carrier jurisdiction for claims for durable medical equipment, prosthetics, orthotics and supplies, and other issues involving suppliers (pg. 56612).
11/15/91	Part A premium for 1992 for the uninsured aged and for certain disabled individuals who have exhausted other entitlement (pg. 58067).
11/15/91	Monthly actuarial rates and monthly Supplementary Medical Insurance premium rates, beginning January 1, 1992 (pg. 58062).

11/15/91	Inpatient hospital deductible and hospital and skilled nursing facility coinsurance amounts for 1992 (pg. 58061).
11/22/91	Quarterly listing of program issuances and coverage decisions (pg. 58913).
11/25/91	Fee schedule for physicians' services (pg. 59502).
11/26/91	Clarification of Medicare's accrual basis of accounting policy; correction (pg. 59979).
11/29/91	Standard claim forms for Part B claims completed and submitted by physicians, suppliers and other persons (pg. 61023).
12/02/91	Medicare and Medicaid Programs; Coordination and Maintenance Committee meeting (pg. 61254).
12/03/91	Reporting requirements for financial relationships between physicians and health care entities that furnish selected items and services (pg. 61374).
12/09/91	Schedule of limits on home health agency costs per visit for cost reporting periods, beginning on or after July 1, 1991 (Pg. 64256).
12/13/91	Monthly actuarial rates and monthly Supplementary Medical Insurance premium rates; correction (pg. 65112).
12/16/91	Conditional designation of states in which Medicare SELECT insurance policies may be issued; correction (pg. 65269).
12/20/91	Payment for customized wheelchairs (pg. 65995).
12/31/91	Update of ambulatory surgical center payment rates and additions to and deletions from the current list of covered surgical procedures (pg. 67666) .
1/02/92	Data standards and methodology used to establish FY 1992 budgets for fiscal intermediaries and carriers (Pg. 57).
1/06/92	HMO qualification determinations and compliance actions (pg. 413).
1/08/92	Schedule of limits on home health agency costs per visit for cost reporting periods, beginning on or after July 1, 1991; correction (pg. 749).

1/22/92	Quarterly listing of program issuances and coverage decisions (pg. 2558).
1/27/92	Prospective payment system for inpatient hospital capital-related costs; correction (pg. 3015).
2/03/92	Recognition of the Joint Commission on the Accreditation of Healthcare Organizations standards for home care organizations (pg. 4044).
2/05/92	Medicare and Medicaid programs; Omnibus nursing home requirements (pg. 4516).
2/28/92	Medicare, Medicaid and Clinical Laboratory Improvement Amendments (CLIA) programs; Regulations implementing the CLIA of 1988 (pg. 7188) .
2/28/92	Clinical Laboratory Improvement Act program fee collection (pg. 7188) .
2/28/92	Medicare and laboratory certification program; Enforcement procedures for laboratories (pg. 7218).
3/06/92	Medicare and Medicaid Programs; Advance directives (pg. 8194).
3/11/92	Physician ownership of, and referrals to, health care entities that furnish clinical laboratory services (Pg. 8588).
3/13/92	Medicare and Medicaid Programs; Omnibus nursing home requirements (pg. 8961).
3/16/92	Quarterly listing of program issuances and coverage decisions (pg. 9127).
4/15/92	Medicare and Medicaid Programs; Small Business Innovation Research Grants for FY 1992 (pg. 13106).
4/24/92	Meeting of the Practicing Physicians Advisory Council (pg. 15090).
4/30/92	Medicare and Medicaid Programs; ICD-9-CM Coordination and Maintenance Committee Meeting (pg. 18519).
5/04/92	Offset of Medicare payments to individuals to collect past-due obligations arising from breach of scholarship and loan contracts (pg. 19089).

5/29/92	Recognition of the Community Health Accreditation Program Standards for home care organizations (pg. 22773).
6/04/92	Changes to the Hospital Inpatient Prospective Payment System and FY 1993 rates (pg. 23618).
6/11/92	Quarterly listing of program issuances and coverage decisions (pg. 24797).
6/12/92	Payment for federally qualified health center services (pg. 24961).
6/16/92	Peer review organization revised scopes of work for the District of Columbia, Puerto Rico, the Virgin islands, and all states except Delaware, Florida, Missouri, Montana, Nebraska, Nevada, Oklahoma, Rhode Island, South Carolina, Washington and Wyoming (pg. 26871).
6/18/92	Carrier jurisdiction for claims for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) and other issues involving suppliers, and criteria and standards for evaluating regional DMEPOS carriers (pg. 27290).
7/01/92	Schedule of limits on home health agency costs per visit for cost reporting periods beginning on or after July 1, 1992 (pg. 29410).
7/08/92	Changes to the Hospital Inpatient Prospective Payment System and FY 1993 rates; correction (pg. 30301).
7/17/92	Program fee collection under Clinical Laboratory Improvement Act (pg. 31664).
7/27/92	Health maintenance organizations; HMO qualification determinations and compliance actions (pg. 33202).
7/31/92	Fee schedules for the services of certified registered nurse anesthetists (pg. 33878).
7/31/92	Clinical Laboratories Improvement Act Program; Granting and withdrawal of deeming authority to private nonprofit accreditation organizations and of CLIA exemption under state laboratory programs (pg.33992).

8/11/92	Medicare and laboratory certification program; Enforcement procedures for laboratories; correction (pg. 35760).
8/11/92	Carrier jurisdiction for claims for durable medical equipment, prosthetics, orthotics supplies (DMEPOS) and other issues involving suppliers, and criteria and standards for evaluating regional DMEPOS carriers; correction (pg. 35760).
8/12/92	Self-implementing coverage and payments provisions: 1990 legislation (pg. 36006).
8/21/92	HHS' recognition of National Association of Insurance Commissioners (NAIC) model standards for the regualtion of "Medigap" insurance policies (pg. 37980).
8/26/92	Beneficiary Counseling and Assistance Grants Program (pg. 38616).
8/27/92	Schedule of limits on home health agency costs per visit for cost reporting periods beginning on or after July 1, 1992; correction (pg. 38959).
8/28/92	Medicare and Medicaid Programs; Survey, certification and enforcement of skilled nursing facilities and nursing facilities (pg. 39278).
9/01/92	Fee schedules for the services of certified registered nurse anesthetists; correction (pg. 39743).
9/01/92	Changes to the Hospital Inpatient Prospective Payment System and FY 1993 rates (pg. 39746).
9/01/92	Meeting of the Practicing Physicians Advisory Council (pg. 39699).
9/11/92	Health maintenance organizations; HMO qualification determinations and compliance actions (pg. 41810).
9/15/92	Fee schedule for physicians' services (pg. 42491).
9/17/92	Schedule of limits on home health agency costs per visit for cost-reporting periods beginning on or after July 1, 1992; correction (pg. 43004).
9/18/92	Criteria and standards for evaluating intermediary and carrier performance during FY 1993 (pg. 43230).

9/22/92	Payment for nursing and allied health education (pg. 43659).
9/23/92	Revaluation of assets (pg. 43906).
9/23/92	Medicare and Medicaid Programs; Requirements for long-term care facilities (pg. 43922).
9/30/92	Self-implementing coverage and payments provisions: 1990 legislation; correction (pg. 45112).

CHAPTER IX

MEDICARE SUPPLEMENTAL INSURANCE FEDERAL CERTIFICATION PROGRAM REPORT

INTRODUCTION

Congressional studies conducted prior to 1980 found many abuses in the sale and marketing of Medicare supplemental or so-called "Medigap" health insurance policies. At that time, no Federal standards existed for Medigap coverage and few States had adopted programs specifically to regulate these types of policies. In order to address this situation, in June 1980, Congress enacted Public Law 96-265, which added Section 1882 to Title XVIII of the Social Security Act, thus establishing Federal minimum standards for Medigap policies.

The original standards established under Section 1882 are often referred to as the "Baucus" standards, since Senator Max Baucus was the chief sponsor of the legislation. The Baucus standards were based primarily on the Medigap provisions contained in the 1979 National Association of Insurance Commissioners (NAIC) Model Regulation To Implement the Individual Accident and Sickness Insurance Minimum Standards Act. The law, however, expanded upon the NAIC requirements by extending its jurisdiction to group policies and by adding specific loss ratio requirements for both group and individual policies. It also provided for the establishment of a Supplemental Health Insurance Panel (the Panel) and a Federal Voluntary Certification Program for Medigap policies. Under this scenario the Panel would approve the regulatory programs of States that adopted requirements at least as stringent as the Federal requirements, and States with programs approved by the Panel would thus avoid imposition of the Voluntary Certification Program. Criminal penalty provisions were also included to address certain abusive sales practices.

The law requires the Secretary of the Department of Health and Human Services (the Secretary) to periodically submit to Congress (not less than once every two years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section. This report is intended to satisfy that requirement.

VOLUNTARY CERTIFICATION PROGRAM

Under the Voluntary Certification Program, insurers selling Medigap policies in States with regulatory programs not approved by the Panel, could voluntarily submit their policies to the Secretary for review. Those policies found to meet or exceed the Federal minimum standards would be certified and the insurer would be authorized to display a Federal emblem on such policies.

The emblem is authorized for use only in States subject to the Federal program, regardless of whether the same policy is marketed in States with Panel-approved programs. Medigap policies approved for sale in States with approved programs, however, are "deemed" to be certified by the Secretary.

The Panel initially determined that the Voluntary Certification Program should be implemented in four States (Massachusetts, New York, Rhode Island and Wyoming) and three territories (Guam, the Virgin Islands, and American Samoa). At the inception of the program, many insurers expressed an interest in submitting their Medigap policies to the Secretary to be certified. Most of these policies were approved in States not subject to the Voluntary Certification Program, however, and could not be considered under the program. Only two insurers actually submitted policies that could be considered for certification and neither was ultimately approved.

Since the Voluntary Certification Program applied to so few jurisdictions, its direct impact was limited. At the same time, however, the program was responsible for the overwhelming success of Section 1882, since it served as an incentive for such a large number of States to adopt their own programs regulating Medigap policies.

IMPLEMENTATION OF MANDATORY CERTIFICATION

OBRA 90 mandated standardization of the Medigap market and made other significant changes to Section 1882. As part of those changes, the Panel was abolished, giving the Secretary sole authority to approve State Medigap regulatory programs, and the Federal certification procedure became mandatory, rather than voluntary, in States failing to gain such approval.

The deadline for States to adopt the Federal requirements as amended by OBRA 90 was July 30, 1992. As of that date, all States had done so, with the exception of Montana and Oregon. These two States were given extensions as allowed for under the statute since they required statutory changes that could not be considered until after the July 30 deadline. Both States subsequently adopted the Federal requirements as part of their regulatory programs. Consequently, the only jurisdictions currently subject to the Federal Certification Program are American Samoa, the Commonwealth of the Northern Mariana Islands, and Guam.

IMPACT OF THE CERTIFICATION PROCEDURE

Since the Secretary has not yet certified any policies, there are no data available to show the direct impact of the certification procedure on market share, value and cost to individuals entitled to benefits under Title XVIII. As stated,

earlier, however, the indirect impact of the program has been its very positive effect of prompting States to implement their own approved regulatory programs for Medigap policies. Many States were initially resistant to some of the standardization and other requirements mandated by OBRA 90. Without the incentive provided by the existence of a mandatory Federal certification program, it is doubtful that all of the States would have adopted the Federal requirements.

PENALTY PROVISIONS

The Medigap law originally established Federal criminal penalties for certain fraudulent or abusive marketing practices. The OBRA 90 amendments revised some of these provisions and Section 1882 currently provides criminal and civil penalties for a number of violations. These include violations such as furnishing false or misleading information for the purpose of obtaining certification, misrepresenting oneself as an agent of the Federal Government for the purpose of selling insurance to supplement Medicare, or knowingly selling duplicative coverage to Medicare beneficiaries. Also, penalties may now be imposed for issuing or selling non-standardized Medigap coverage, failing to make available a policy containing the "core" benefits required by OBRA 90, or for failing to provide certain disclosures when selling such coverage.

HCFA continues to collect Medigap complaint information from its 10 regional offices and to coordinate such activity with the Office of the Inspector General (OIG) and the Department of Justice (DOJ). The number of complaints reported via HCFA's regional offices has, however, decreased dramatically in recent years. While several complaints were referred to the OIG for possible prosecution, none of these were found to be subject to the Federal penalty provisions.

One of the reasons for the decline in the number of complaints reported via HCFA's regional offices is the fact that a toll-free telephone number now exists for reporting Medigap complaints. This toll free telephone number is published in both the "Medicare Handbook" and the "Guide to Health Insurance for People With Medicare" which is developed jointly by HCFA and the NAIC. Most of the complaints received by the hotline, however, do not involve Federal violations and are referred to the appropriate State insurance departments for resolution.

Although the Federal penalties have not yet had to be utilized, it is recommended that they be retained. At the present time, HCFA is coordinating its efforts in this area with the NAIC which maintains an insurance complaint database. HCFA is currently utilizing the NAIC's system to develop a Medigap complaint database to track complaints received by States. Implementing these types of resources may increase the

possibility of utilizing the Federal penalties, particularly the recently added civil money penalties.

MEDIGAP STANDARDIZATION

One of the primary goals of the OBRA 90 Medigap amendments was to simplify and standardize the Medigap market. The NAIC Model Regulation for Medigap policies, being the key part of the Federal standards, was amended accordingly. The NAIC developed 10 standard Medigap benefit packages that include a "core" package, plus 9 others that build on the core. Due to an exception permitted by OBRA 90, the States of Massachusetts, Minnesota, and Wisconsin were granted waivers which allowed them to retain their "alternative" standardization requirements for Medigap policies. These States are, however, still subject to all other requirements of Section 1882.

As previously noted, all States have now adopted the Federal standards for Medigap policies as amended by OBRA 90. The Federal statute allows a State to restrict the packages that may be sold within its borders, but does require that each State must allow the sale of the core package. Delaware, Pennsylvania and Vermont are the only States that opted not to allow the sale of all 10 packages. Delaware and Pennsylvania allow 6 of the 10 packages to be sold, while Vermont permits 7.

CHAPTER X

Report on Medicare Validation Surveys of Hospitals Accredited by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

This report is a summary of the analysis of the validation surveys conducted in Joint Commission accredited hospitals during fiscal year 1992 (FY 92). This report also contains a summary of the analysis of the validation surveys conducted in fiscal year 1991 (FY 91). The 1991 analysis is included in this report because at the time the 1991 Medicare Annual Report to Congress was released, problems existed with the crosswalk of Joint Commission standards to Medicare requirements and a full analysis of the validation surveys could not be completed. A full report containing all of the statistical data, findings and discussions for the FY 91 and FY 92 validation surveys may be obtained by contacting the Health Care Financing Administration (HCFA) and requesting the following: Attachment to the Report on Medicare Validation Surveys of Hospitals Accredited by the Joint Commission on Accreditation of Healthcare Organizations, Fiscal Year 1991 and Fiscal Year 1992.

INTRODUCTION

Each year, the Health Care Financing Administration (HCFA) selects a statistical sample from the approximately 5,200 Joint Commission accredited hospitals for validation surveys. The purpose of the validation program is to determine whether the Joint Commission's accreditation process provides reasonable assurance that accredited hospitals comply with the statutory requirements at section 1861(e) of the Social Security Act for participation in the Medicare program.

Validation surveys are conducted by Medicare State survey agencies (SAs). In addition to conducting validation surveys from the statistical sample selected by HCFA, the SAs also conduct validation surveys in response to substantial allegations of the existence of significant deficiencies which would, if present, adversely affect the health and safety of patients.

In 1991, HCFA began three separate sample categories for sample validation surveys: regular sample (hospitals surveyed within 60 days after the Joint Commission accreditation survey), 18 month sample (hospitals surveyed at the midpoint of their 3-year Joint Commission accreditation cycles), and conditional sample (hospitals

surveyed for selected Medicare requirements based on the requirements not met during their accreditation surveys that caused the Joint Commission to issue a conditional accreditation decision).

During FY 91, the SAs conducted 227 sample validation surveys (see Appendix A and B) and investigated 150 complaints which led to 45 full allegation surveys (see Appendix C and D). During FY 92, the SAs conducted 167 sample validation surveys (see Appendix E and F) and investigated 628 complaints which led to 34 full allegation surveys (see Appendix G and H). These numbers do not include investigations of alleged violations of section 1867 of the Social Security Act, Examination and Treatment for Emergency Medical Conditions and Women in Labor.

EVALUATION METHODOLOGY

The Joint Commission's letters of recommendation and survey reports and the Federal Form HCFA-2567, Statement of Deficiencies and Plan of Correction, as completed by the SAs, were used to identify each hospital's deficiencies. To evaluate the data, HCFA and the Joint Commission developed an extensive crosswalk between the Medicare conditions of participation (CoPs) and the Joint Commission standards. The crosswalk assigns a Medicare data tag (requirement) to each Joint Commission standard that is comparable to a Medicare requirement. The Joint Commission modified some of its standards and added others between 1991 and 1992; therefore, two separate crosswalks were necessary to analyze the FY 91 and FY 92 data.

Deficiency data was analyzed for 18 of the 20 Medicare hospital CoPs. The 20 Medicare health and safety CoPs are as follows:

Federal, State & local laws
Quality Assurance
Nursing Services
Radiologic Services
Physical Environment
Food and Dietetic Services
Infection Control
Anesthesia Services
Outpatient Services
Rehabilitation Services
Respiratory Care Services
Governing Body
Medical Staff
Pharmaceutical Services
Laboratory Services
Medical Records
Utilization Review
Surgical Services
Nuclear Medicine Services
Emergency Services

The Utilization Review CoP was not surveyed by the SAs because accredited hospitals are subject to binding review by their State Peer Review Organizations (PRO), and the

Medicare Utilization Review CoP does not apply when the PRO assumes the review for the hospital. In addition, a comparative analysis of the Laboratory Services requirements was not performed because under the Clinical Laboratory Improvement Amendments of 1988, laboratory certification is now a separate program.

Survey findings were analyzed in terms of the number, severity and types of requirements found deficient. The **number** of deficiencies refers to the total number of health and safety and Life Safety Code (LSC) deficiencies cited across all deficiency type categories in the sample validation hospitals. The **severity** of the deficiencies reflects the level of the deficiencies: conditions, standards and other requirements. The **type** of deficiencies refers to the category of the health and safety deficiencies identified, e.g., Nursing Services deficiencies, Medical Records deficiencies, etc.

The objective of the analysis is to determine whether the Joint Commission's accreditation process provides reasonable assurance that accredited hospitals comply with the statutory requirements for participation in the Medicare program. To make this determination, parametric statistical tests (t-test, Pearson correlation coefficient, and a coefficient of determination) were used to explore hypotheses about the number, severity and type of deficiencies.

FY 91 ANALYSIS

A. Sample Validation Surveys

1. Regular Sample Findings

a. The data indicate that there was a significant difference in the aggregate number of health and safety deficiencies cited with the Joint Commission identifying far more total numbers of general health and safety deficiencies. In fact, the Joint Commission identified 63 percent more total numbers of general health and safety deficiencies than the SAs. However, the SAs identified more than 2 times as many LSC deficiencies. Overall, the Joint Commission identified 14 percent more deficiencies (total health and safety plus total LSC) than the SAs. It was expected that the Joint Commission would identify a larger number of deficiencies. Since regular sample validation surveys are conducted within 60 days after the accreditation survey, the

hospitals would most likely have taken corrective actions to address the problems identified by the Joint Commission before the SAs arrived to survey the hospital. Only 9 percent of the total number of health and safety deficiencies identified by the surveyors could be explained by survey type (accreditation or validation). This suggests that the Joint Commission standards support the Medicare CoPs to the point that Joint Commission accreditation provides reasonable assurance that accredited hospitals meet Federal requirements.

b. The data indicate that there was a significant difference in the nature of the health and safety deficiencies cited with the Joint Commission citing many more deficiencies in all severity categories. The Joint Commission surveyors cited 62 percent more condition level deficiencies during accreditation surveys than the SAs. The Joint Commission cited more hospitals deficient at the condition level with Quality Assurance, Infection Control, and Nursing Services. The SAs cited more hospitals deficient at the condition level with Federal, State and local laws, Governing Body, Pharmaceutical Services and Physical Environment (which includes the standards for LSC). The SAs cited 22 hospitals (12.4 percent) out of compliance with the LSC, whereas the Joint Commission only cited 1 hospital out of compliance with the LSC.

c. For the 177 hospitals in the regular sample, approximately 20.3 percent (36 hospitals) failed to comply with the Medicare CoPs at the condition level at the time of the validation surveys; therefore, these hospitals were placed under SA monitoring. However, this number was significantly less than FY 90 when 25.8 percent of the hospitals subject to validation surveys were found deficient in one or more Medicare CoPs at the condition level. The Medicare CoPs found deficient most frequently during FY 91 regular sample validation surveys were Physical Environment and Quality Assurance. None of the hospitals with condition level deficiencies were terminated from Medicare participation; they were all able to correct their deficiencies prior to their scheduled termination dates.

d. For deficiencies within each CoP, the Joint Commission and the SAs found the same types of deficiencies in almost half of the CoP categories. Statistical tests revealed significant differences in the following deficiency type categories: Federal,

State and local laws, Governing Body, Quality Assurance, Medical Staff, Nursing Services, Pharmaceutical Services, Food and Dietetic Services, Infection Control, Anesthesia Services and Respiratory Care Services. However, the strength of the association between survey type (accreditation or validation) and deficiency types was low. The Joint Commission identified more deficiencies than the SAs in the following deficiency type categories: Federal, State and local laws, Governing Body, Quality Assurance, Medical Staff, Nursing Services, Physical Environment and Infection Control. The SAs identified more deficiencies in the areas of Medical Records, Pharmaceutical Services, Food and Dietetic Services, Anesthesia Services, Emergency Services, and Respiratory Care Services. The SAs and Joint Commission identified virtually the same number of deficiencies in the deficiency type category Surgical Services.

2. 18 Month Sample Findings

   a. Review of the survey documents revealed that the hospitals subject to validation surveys at the midpoint of their accreditation cycle had 51 percent more total numbers of general health and safety deficiencies identified during their accreditation surveys than 18 months later as identified by the SAs during the validation surveys. However, statistical tests indicated the difference in the total number of general health and safety deficiencies (conditions plus standards plus elements across all deficiency type categories) cited in the accreditation and validation surveys was not significant. The SAs identified 69 percent more LSC deficiencies than the Joint Commission. Overall, the Joint Commission identified 15 percent more total deficiencies (health and safety plus LSC). Only 5 percent of the total number of health and safety deficiencies identified in the 18 month sample could be explained by survey type (accreditation or validation). This suggests that the Joint Commission standards support the Medicare CoPs to the point that Joint Commission accreditation provides reasonable assurance that accredited hospitals meet Federal requirements.

   b. For the severity of health and safety deficiencies in the 18 month sample, the Joint Commission surveyors cited 3 times more condition level deficiencies, 2 times more standard level deficiencies, and 27 percent more of the other requirements than the SA surveyors. Statistical tests indicated that the

difference in the nature of the condition level deficiencies and other requirements cited in the accreditation and 18 month sample validation surveys was not significant. However, at the standard level, the difference was significant. The strength of the association was tested and data indicate that at the condition level, only 4 percent of the total number of condition level deficiencies cited could be explained by survey type, at the standard level, only 15 percent of the total number of deficiencies could be explained by survey type and only 2 percent of the total number of other requirements cited could be explained by survey type. The Joint Commission cited more hospitals deficient at the condition level with Quality Assurance, Infection Control, Nursing Services and Pharmaceutical Services. The SAs cited more hospitals deficient with the Physical Environment CoP (which includes the LSC standards). Remarkably, both accreditation and the 18 month sample validation surveys revealed the same number of hospitals out of compliance with LSC.

c. For the 33 hospitals in the 18 month sample, validation surveys revealed that approximately 33.3 percent (11 hospitals) failed to comply with the Medicare CoPs at the condition level; therefore, these hospitals were placed under SA monitoring. The Medicare CoPs found deficient most frequently by the SAs during 18 month sample validation surveys were Physical Environment and Infection Control. None of the condition level deficient hospitals in this sample were terminated from Medicare participation; they were all able to correct their deficiencies prior to their scheduled termination dates.

d. For deficiencies within each CoP, the Joint Commission and the SAs found the same types of deficiencies in 3/4 of the CoP categories. The associations, however, were low. For example, for Anesthesia Services, only 5 percent of the deficiencies found by surveyors are explained by survey type alone. Significant differences were found in only the following deficiency type categories: Federal, State and local laws, Governing Body, Quality Assurance, Medical Staff and Rehabilitation Services. The SAs identified a larger number of deficiencies than accreditation surveys in the following deficiency type categories: Medical Records, Pharmaceutical Services, Food and Dietetic Services, Surgical Services and Anesthesia Services. The Joint Commission identified more deficiencies than the SAs in the following deficiency type

categories: Federal, State and local laws, Governing Body, Quality Assurance, Medical Staff, Nursing Services, Radiologic Services, Physical Environment, Infection Control, Outpatient Services and Rehabilitation Services.

3. Conditional Sample

   a. The data indicate that there was a significant difference in the aggregate number of health and safety deficiencies cited with the Joint Commission identifying more in terms of total numbers of general health and safety deficiencies (conditions, standards and elements combined across all deficiency type categories). The Joint Commission identified 10 times more general health and safety deficiencies than the SAs and 6 times as many LSC deficiencies. Overall, the Joint Commission identified 9 times more total deficiencies (health and safety plus LSC). Seventy-four percent of the total number of health and safety deficiencies identified in the conditional sample could be explained by survey type (accreditation or validation). This is a stronger relationship than in the regular and 18 month samples.

   b. The data indicate that there was a significant difference in the nature of the health and safety deficiencies cited with the Joint Commission citing many more deficiencies in all severity categories. This was expected because the accreditation surveys reviewed all of the Joint Commission standards and the conditional sample validation surveys focused only on those Medicare CoPs that caused the hospital to receive a conditionally accredited decision from the Joint Commission.

   c. For the 17 hospitals in the conditional sample, validation surveys revealed that only 1 hospital failed to comply with the Medicare requirements. The LSC was not met for this hospital; however, the hospital was not terminated from the Medicare program because it corrected its deficiencies prior to its scheduled termination date.

   d. For deficiencies within each CoP, the Joint Commission and the SAs found the same types of deficiencies in 1/4 of the CoP categories. Significant differences were found in the following deficiency type categories: Federal, State and local laws, Governing Body, Quality Assurance, Medical Staff, Nursing Services, Medical Records,

Pharmaceutical Services, Radiologic Services, Food and Dietetic Services, Physical Environment, Infection Control and Respiratory Care Services. The Joint Commission identified more deficiencies than the SAs in all deficiency type categories for the conditional sample.

B. Allegation Surveys

For the FY 91 allegation surveys, 45 hospitals were out of compliance at the condition level. The FY 91 data show an increase from FY 90 in the percentage of hospitals found to have one or more Medicare CoPs out of compliance as a result of allegation investigations. This is because the number of complaint investigation surveys conducted in FY 91 was significantly lower than in FY 90, causing a higher percentage to be out of compliance in FY 91. Of the 150 hospitals surveyed as the result of substantial allegations, 27 percent were not in compliance with one or more Medicare CoPs as compared to 5 percent from the previous report period (FY 90).

C. LSC

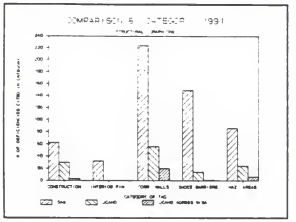
As part of the Physical Environment condition of participation, hospitals must meet the Life Safety Code (LSC) of the National Fire Protection Association. The LSC is a consensus standard adopted by reference in Federal regulation. The LSC provides a reasonable level of safety from fire and other emergencies, and has been one of the most difficult requirements to meet for both accredited and nonaccredited hospitals.

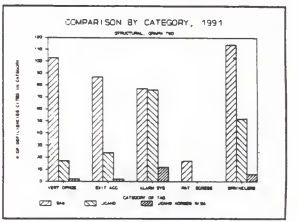
There are discrepancies in the Joint Commission LSC accreditation and the SAs LSC validation survey findings.

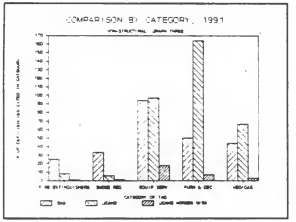
The SAs LSC surveyors found the LSC out of compliance at the condition level in 22 hospitals in the regular sample, while the Joint Commission LSC surveyors found the LSC out of compliance at the condition level in 1 hospital for the regular sample. This indicates that the SA LSC surveyors survey the LSC more vigorously than the Joint Commission LSC surveyors.

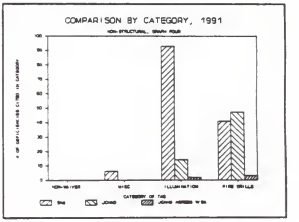
The following bar graphs illustrate the pattern of the citation of LSC deficiencies for all of the hospitals in the 1991 sample. The graphs show a comparison of the LSC deficiencies cited by the SAs LSC surveyors, the Joint Commission LSC surveyors, and how frequently the two agencies cited the same LSC deficiency in the same hospital

for each category illustrated. Each category represents a logical grouping of LSC requirements, and may include as few as one or as many as 10 requirements. The category of corridor walls includes requirements for: the fire resistive capabilities of the corridor walls; the fire resistive capabilities of the doors located in the corridor walls; the allowable size and materials of visual panels in doors located in corridor walls; devices which automatically close doors located in certain areas upon the activation of the alarm system, the smoke detectors, and the automatic sprinkler system; and signs indicating that doors without automatic door closers must be kept closed. Therefore, while the category of corridor walls shows a total of 220 state agency deficiency citations, it does not represent findings in 220 hospitals (see graph #1, 1991).









There are three bars for each category of requirements depicted in the illustrations. The first bar of each grouping of requirements represents the total number of times the SA cited LSC deficiencies in that category of

requirements. The second bar represents the total number of times the Joint Commission LSC surveyors cited LSC deficiencies in that category of requirements. The third bar represents the number of times both the Joint Commission LSC surveyors and the SA cited the same LSC deficiency in the same hospital in that category of requirements.

1. SAs LSC surveyors cite more LSC deficiencies than the Joint Commission LSC surveyors. This indicates that the SA LSC surveyors survey the LSC more vigorously than the Joint Commission LSC surveyors.

2. The SAs LSC surveyors and the Joint Commission LSC surveyors cite different LSC deficiencies in the same hospitals.

   a. LSC deficiencies cited by the SAs LSC surveyors that were not cited by the Joint Commission LSC surveyors tend to be for LSC requirements that are structural in nature. Structural requirements include specific LSC requirements for the design of the building, the materials with which it is built, and the design and operation of the fire protective devices of a hospital. These types of LSC requirements are stable and do not change on a day to day basis. It is likely that structural LSC deficiencies cited by SAs LSC surveyors within 60 days of the accreditation survey were in existence at the time of the Joint Commission accreditation survey.

   b. LSC deficiencies cited by the Joint Commission LSC surveyors that were not cited by the SAs LSC surveyors tend to be for LSC requirements that are not structural in nature. Non-structural requirements include the LSC requirements for the placement and maintenance of fire extinguishers, smoking regulations, and furnishings and decorations. These types of LSC deficiencies can be corrected quickly by replacing trash cans with approved types, writing or enforcing smoking regulations, and having routine fire extinguisher maintenance performed. When the SAs conducted a LSC survey within 60 days of the accreditation survey, these types of LSC deficiencies could have already been corrected.

   c. The category of alarm systems in graph two illustrates that while the SAs LSC surveyors and the Joint Commission LSC surveyors found approximately the same number of LSC deficiencies for this category of requirements, those findings were made in different hospitals.

d. In the category of alarm systems, the Joint Commission LSC surveyors made 89% of their citations of LSC deficiencies for requirements which are determined by record review. SAs LSC surveyors made 51% of their citations of LSC deficiencies for requirements which require surveyor onsite inspection of the alarm system.

e. Please note, however, that if the Joint Commission establishes an equivalency for one of the LSC requirements (waiver), deficiencies for that requirement are not cited on their survey report form. Therefore, it is possible that the Joint Commission LSC surveyors found more LSC deficiencies than were indicated by the data. HCFA's data includes LSC deficiencies that were cited for requirements for which a later equivalency or waiver was accepted.

3. There are discrepancies in the LSC deficiencies cited for requirements related to building construction type. SAs LSC surveyors cited twice as many LSC deficiencies in the category of building construction as the Joint Commission LSC surveyors. Determination of the building construction type of the hospital is crucial to determining whether an automatic sprinkler system is required.

   a. The Joint Commission LSC surveyors and the SAs LSC surveyors determine building construction type by reviewing construction information provided by the hospital and verifying this information by onsite inspection. In this category of requirements the SAs LSC surveyors cited 61 LSC deficiencies and the Joint Commission LSC surveyors cited 30 LSC deficiencies. However, the Joint Commission LSC surveyors cited only 4 of the specific LSC deficiencies cited by the SAs LSC surveyors. This suggests that the Joint Commission LSC surveyors and SAs LSC surveyors reach different conclusions based on the construction information provided by the hospital and the onsite inspections each agency performs to verify that information.

4. The SAs LSC surveyors are given more training that is relevant to the LSC than the Joint Commission LSC surveyors.

   a. For the period of this report, the Joint Commission training for their LSC surveyors consisted of an orientation and general LSC training based on a text of the LSC. The review of the LSC text, to be

completed before the class, and the orientation and general LSC training total about 30 hours. The Joint Commission training program is being modified and will include the use of practical examples and simulated experience in surveying for the LSC.

b. SAs LSC surveyors attend HCFA Basic LSC training and Fire Safety Evaluation System/Health Care courses, a total of about 64 hours of training.

5. The professional background of SAs LSC surveyors and Joint Commission LSC surveyors differs.

a. Approximately half of the State health departments sub-contract the survey of the LSC to their State fire authority. The majority of the rest of the States assign this task to surveyors with architectural or engineering background. Overall, 90% of SAs LSC surveyors are LSC specialists, whose professional background enhances their ability to understand and evaluate the requirements of the LSC.

b. The Joint Commission assigns the survey of the LSC to the member of the accreditation survey team who is a hospital administrator. The Joint Commission relies exclusively on their surveyor training program to familiarize their surveyors with the requirements of the LSC.

c. The SAs LSC surveyors have more expertise than the Joint Commission LSC surveyors, as evidenced by their professional background and the specific LSC training they receive.

FY 92 ANALYSIS

A. Sample Validation Surveys

1. Regular Sample Findings

a. The data indicate that there was a significant difference in the aggregate number of health and safety deficiencies cited with the Joint Commission identifying far more total numbers of general health and safety deficiencies. In fact, the Joint Commission identified 68.3 percent more total numbers of general health and safety deficiencies than the SAs. However, the SAs identified almost 2 times as

many LSC deficiencies. Overall, the Joint Commission identified 21.7 percent more deficiencies (total health and safety plus total LSC) than the SAs. Only 12 percent of the total number of health and safety deficiencies identified by the surveyors could be explained by survey type (accreditation or validation). This suggests that the Joint Commission standards support the Medicare CoPs to the point that Joint Commission accreditation provides reasonable assurance that accredited hospitals meet Federal requirements.

b. The data indicate that there was a significant difference in the nature of the health and safety deficiencies cited with the Joint Commission citing many more deficiencies in all severity categories. The Joint Commission surveyors cited 68 percent more condition level deficiencies during accreditation surveys than the SAs. The Joint Commission cited more hospitals deficient at the condition level with Quality Assurance, Infection Control, Nursing Services, and Physical Environment. The SAs cited more hospitals deficient at the condition level with Physical Environment, Infection Control and Quality Assurance. In addition, the SAs cited 34 hospitals (25 percent) out of compliance with the LSC, whereas the Joint Commission cited none.

c. For the 136 hospitals in the regular sample, approximately 35.3 percent (48 hospitals) failed to comply with the Medicare CoPs at the condition level at the time of the validation surveys; therefore, these hospitals were placed under SA monitoring. This was an increase from FY 91 when 20.3 percent of the hospitals were found deficient by the SAs in one or more Medicare CoPs at the condition level. Nevertheless, this is an improvement over the average of all previous report periods(1974-1990) where 42.4 percent of the hospitals were found out of compliance by the SAs at the condition level. The Medicare CoP cited most frequently during FY 92 regular sample validation surveys were Physical Environment and Infection Control. None of the 48 hospitals with condition level deficiencies were terminated from Medicare participation; they were all able to correct their deficiencies prior to their scheduled termination dates.

d. For deficiencies within each CoP, the Joint Commission and the SAs found the same types of deficiencies in almost half of the CoP categories.

Statistical tests revealed significant differences in only the following deficiency type categories: Federal, State and local laws, Governing Body, Quality Assurance, Medical Staff, Nursing Services, Pharmaceutical Services, Food and Dietetic Services, Infection Control, Anesthesia Services and Respiratory Care Services. However, the strength of the association between survey type (accreditation or validation) and deficiency types was low. The Joint Commission identified more deficiencies than the SAs in the following deficiency type categories: Federal, State and local laws, Governing Body, Quality Assurance, Medical Staff, Nursing Services, Medical Records, Physical Environment and Infection Control. The SAs identified more deficiencies in the areas of
Pharmaceutical Services, Food and Dietetic Services, Surgical Services, Anesthesia Services, Emergency Services and Respiratory Care Services. The SAs and Joint Commission identified virtually the same number of deficiencies in the deficiency type categories Radiologic Services, Nuclear Medicine Services, Outpatient Services, and Rehabilitation Services.

2. 18 Month Sample Findings

   a. Review of the survey documents revealed that the hospitals subject to validation surveys at the midpoint of their accreditation cycle had 38.7 percent more total numbers of general health and safety deficiencies identified during their accreditation surveys than 18 months later as identified by the SAs during the validation surveys. However, statistical tests indicated the difference in the total number of general health and safety deficiencies cited in the accreditation and validation surveys was not significant. The SAs identified 3 times more LSC deficiencies than the Joint Commission. Overall, the SAs identified 13.6 percent more total deficiencies (health and safety plus LSC). Only 4 percent of the total number of health and safety deficiencies identified in the 18 month sample could be explained by survey type (accreditation or validation). This suggests that the Joint Commission standards support the Medicare CoPs to the point that Joint Commission accreditation provides reasonable assurance that accredited hospitals meet Federal requirements.

   b. For the severity of health and safety deficiencies in the 18 month sample, the Joint Commission surveyors cited almost the same number of condition level

deficiencies and other requirements as the SAs, but almost 3 times as many standard level deficiencies. Statistical tests indicated that the difference in the nature of the condition level deficiencies and other requirements cited between the accreditation and 18 month sample validation surveys was not significant. However, at the standard level, the difference was significant. The strength of the association was tested and data indicate that at the condition level, only 1 percent of the total number of condition level deficiencies cited could be explained by survey type, at the standard level, only 23 percent of the total number of deficiencies could be explained by survey type and only 1 percent of the total number of other requirements cited could be explained by survey type. The Joint Commission cited more hospitals deficient at the condition level with Quality Assurance. The SAs cited more hospitals deficient with the Physical Environment CoP. The LSC was cited out of compliance in 2 hospitals by the Joint Commission and 4 hospitals by the SAs.

c. For the 17 hospitals in the 18 month sample, validation surveys revealed that approximately 41.2 percent (7 hospitals) failed to comply with the Medicare CoPs at the condition level; therefore, these hospitals were placed under SA monitoring. The Medicare CoP found deficient most frequently during 18 month sample validation surveys was Physical Environment. None of the hospitals with condition level deficiencies hospitals were terminated from Medicare participation. They were all able to correct their deficiencies prior to their scheduled termination dates.

d. For deficiencies within each CoP, the Joint Commission and the SAs found the same types of deficiencies in 3/4 of the CoP categories. The associations, however, were low. For example, for Pharmaceutical Services, only 18 percent of the deficiencies found by surveyors are explained by survey type alone. Significant differences were found in only the following deficiency type categories: Federal, State and local laws, Governing Body, Quality Assurance, Medical Staff, Pharmaceutical Services and Food and Dietetic Services. The SAs identified a larger number of deficiencies than accreditation surveys in the following deficiency type categories: Medical Records, Pharmaceutical Services, Food and Dietetic Services, Surgical Services, Anesthesia Services, Emergency Services and Respiratory Care Services.

The Joint Commission identified more deficiencies than the SAs in the following deficiency type categories: Federal, State and local laws, Governing Body, Quality Assurance, Medical Staff, Radiologic Services, Physical Environment, and Infection Control.

3. Conditional Sample Findings

   a. The data indicate that there was a significant difference in the aggregate number of health and safety deficiencies cited with the Joint Commission identifying more in terms of total numbers of general health and safety deficiencies. The Joint Commission identified more than 8 times the amount of health and safety deficiencies identified by the SA and more than 2 times the number of LSC deficiencies. Overall, the Joint Commission identified almost 6 times more total deficiencies (health and safety plus LSC). Eighty-four percent of the total number of health and safety deficiencies identified in the conditional sample could be explained by survey type (accreditation or validation). This is a stronger relationship than in the regular and 18 month samples.

   b. The data indicate that there was a significant difference in the nature of the health and safety deficiencies cited with the Joint Commission citing many more deficiencies in all severity categories. This was expected because the accreditation surveys reviewed all of the Joint Commission standards and the conditional sample validation surveys focused only on those Medicare CoPs that caused the hospital to receive a conditionally accredited decision from the Joint Commission. The Joint Commission cited more hospitals deficient at the condition level with Quality Assurance, Nursing Services and Infection Control.

   c. For the 14 hospitals in the conditional sample, validation surveys indicated that 2 hospitals (14.3 percent) failed to comply with the Medicare CoPs at the condition level; therefore, these hospitals were placed under SA monitoring. Both hospitals were out of compliance with the Quality Assurance CoP and 1 of the hospitals was also out of compliance with Medical Staff CoP. Both of the hospitals were able to correct their deficiencies prior to their scheduled termination dates.

   d. For deficiencies within each CoP, the Joint

Commission and the SAs found the same types of deficiencies in 1/4 of the CoP categories. Significant differences were found in the following deficiency type categories: Federal, State and local laws, Governing Body, Quality Assurance, Medical Staff, Nursing Services, Pharmaceutical Services, Radiologic Services, Food and Dietetic Services, Physical Environment, Infection Control, Surgical Services and Rehabilitation Services. The Joint Commission identified more deficiencies than the SA surveyors in all deficiency type categories except for 1 deficiency identified by the SAs in Emergency Services. The Joint Commission identified no deficiencies in this category.

B. Allegation Surveys

For the FY 92 allegation surveys, 34 hospitals were out of compliance at the condition level. The FY 92 data show a decrease from FY 91 in the percentage of hospitals found to have one or more Medicare CoPs out of compliance as a result of allegation investigations FY 91. This is because the universe of complaint investigation surveys conducted in FY 92 was significantly higher than in FY 91. Of the 628 hospitals surveyed as the result of substantial allegations, 5 percent were not in compliance with one or more Medicare CoPs as compared to 27 percent from the previous report period (FY 91).

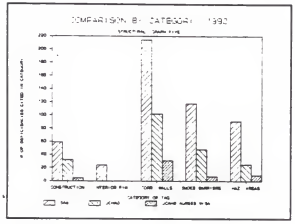
C. LSC

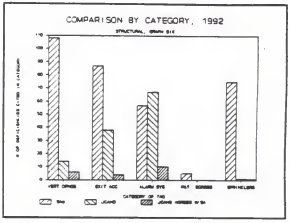
As part of the Physical Environment condition of participation, hospitals must meet the Life Safety Code (LSC) of the National Fire Protection Association. The LSC is a consensus standard adopted by reference in Federal regulation. The LSC provides a reasonable level of safety from fire and other emergencies, and has been one of the most difficult requirements to meet for both accredited and nonaccredited hospitals.

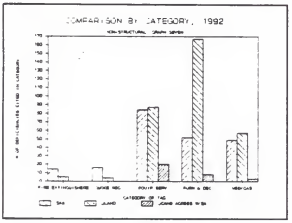
Consistent with the findings for the 1991 validation surveys, there are discrepancies in the Joint Commission LSC accreditation and SAs LSC validation survey findings.

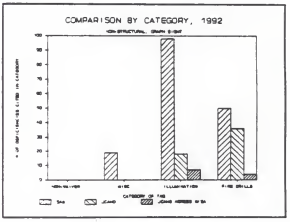
The SAs found the LSC out of compliance at the condition level in 34 hospitals in the regular sample, while the Joint Commission did not find the LSC out of compliance at the condition level in any hospital for the regular sample. This indicates that the SA LSC surveyors survey the LSC more vigorously than the Joint Commission LSC surveyors.

The following bar graphs illustrate the pattern of the citation of deficiencies for all of the hospitals in the 1992 sample. The graphs show a comparison of the deficiencies cited by the SAs, the Joint Commission, and how frequently the two agencies cited the same deficiency in the same hospital for each category of requirements illustrated. Each category represents a logical grouping of LSC requirements, and may include as few as one or as many as 10 requirements. The category of corridor walls includes requirements for: the fire resistive capabilities of the corridor walls; the fire resistive capabilities of the doors located in the corridor walls; the allowable size and materials for visual panels in doors located in corridor walls; devices which automatically close doors located in certain areas upon the activation of the alarm system, the smoke detectors, and the automatic sprinkler system; and signs indicating that doors without automatic door closers must be kept closed. Therefore, while the category of corridor walls shows a total of 214 state agency deficiency citations, it does not represent findings in 212 hospitals (see graph #5, 1992).









There are three bars for each category of LSC requirements depicted in the illustrations. The first bar of each category of requirements represents the total number of times the SAs LSC surveyors cited LSC deficiencies in that category of LSC requirements. The second bar represents the total number of times the Joint Commission LSC surveyors cited LSC deficiencies in that category of LSC requirements. The third bar represents the number of times both the Joint Commission LSC surveyors and the SAs LSC surveyors cited the same LSC deficiency in the same hospital in that category of LSC requirements.

1. SAs cite more LSC deficiencies than the Joint Commission. This indicates that the SA LSC surveyors survey the LSC more vigorously than the Joint Commission LSC surveyors.

2. The SAs and the Joint Commission cite different LSC deficiencies in the same hospitals.

   a. Deficiencies cited by the SAs that were not cited by the Joint Commission tend to be for LSC requirements that are structural in nature. Structural LSC requirements include specific requirements for the design of the building, the materials with which it is built, and the design and operation of the fire protective devices of a hospital. These types of LSC requirements are stable and do not change on a day to day basis. It is likely that structural LSC deficiencies cited by SAs LSC surveyors within 60 days of the accreditation survey were in existence at the time of the Joint Commission accreditation survey.

   b. Deficiencies cited by the Joint Commission that were not cited by the SAs tend to be for LSC requirements that are not structural in nature. Non-structural LSC requirements include the requirements for the placement and maintenance of fire extinguishers, smoking regulations, and furnishings and decorations. These types of LSC deficiencies can be corrected quickly, e.g., by replacing trash cans with approved types, writing or enforcing smoking regulations, or having routine fire extinguisher maintenance performed. When the SAs LSC surveyors conducted a LSC survey within 60 days of the accreditation survey, these types of LSC deficiencies could have already been corrected.

   c. The category of equipment services in graph seven illustrates that while the SAs LSC surveyors and the Joint Commission LSC surveyors cited approximately

the same number of LSC deficiencies for this category of LSC requirements, those findings were made in different hospitals.

d. In the category of LSC requirements for alarm systems, the Joint Commission LSC surveyors made 88% of their citations for LSC requirements which are determined by record review, while the SAs LSC surveyors made 50% of their citations of LSC deficiencies for LSC requirements which require surveyor onsite inspection of the alarm system.

e. Please note, however, that if the Joint Commission establishes an equivalency for one of the LSC requirements (waiver), LSC deficiencies for that requirement are not cited on their survey report form. Therefore, it is possible that the Joint Commission found more LSC deficiencies than were indicated by the data. HCFA's data includes the LSC deficiencies that were cited for requirements for which a later equivalency or waiver was accepted.

3. There are discrepancies in the LSC deficiencies cited for requirements related to building construction type. SAs LSC surveyors cited approximately twice as many LSC deficiencies as the Joint Commission LSC surveyors. Determination of the building construction type of the hospital is crucial to determining whether an automatic sprinkler system is required.

   a. The Joint Commission LSC surveyors and the SAs LSC surveyors determine building construction type by reviewing construction information provided by the hospital and verifying this information by onsite inspection. In this category of LSC requirements the SAs LSC surveyors cited 59 LSC deficiencies and the Joint Commission cited 32 LSC deficiencies. However, the Joint Commission LSC surveyors cited only 5 of the specific LSC deficiencies cited by the SAs. This suggests that the Joint Commission and SAs LSC surveyors reach different conclusions based on the construction information provided by the hospital and the onsite inspections each agency performs to verify that information.

4. The SAs LSC surveyors are given more training that is relevant to the LSC than the Joint Commission LSC surveyors.

   a. For the period of this report, the Joint Commission training for their LSC surveyors consisted of an orientation and general LSC training based on a text

of the LSC. The review of the LSC text to be completed before the class, and the orientation and general LSC training total about 30 hours. The Joint Commission training program is being modified and will include the use of practical examples and laboratory experience in surveying for the LSC.

b. SAs LSC surveyors attend HCFA Basic Life Safety Code training and Fire Safety Evaluation System/Health Care courses, a total of about 64 hours of training.

5. As was previously stated for the 1991 report, the professional background of SAs and Joint Commission LSC surveyors is different.

a. Approximately half of the State health departments sub-contract the survey of the LSC to their State Fire Authority. The majority of the rest of the States assign this task to LSC surveyors who have a background in architecture, engineering or fire protection. Overall, 90% of SAs LSC surveyors are LSC specialists, whose professional background enhances their ability to understand and evaluate the requirements of the LSC.

b. The Joint Commission assigns the survey of the LSC to the member of the accreditation survey team who is a hospital administrator. The Joint Commission relies exclusively on their surveyor training program to familiarize this surveyor with the requirements of the LSC.

c. The SAs LSC surveyors have more expertise than the Joint Commission LSC surveyors, as evidenced by their professional background and the greater amount of LSC training they are provided.

6. SAs LSC surveyors perform comparably regardless of whether they are State Fire Authority surveyors or State health department surveyors.

a. We compared the patterns of LSC deficiencies cited by SAs which sub-contract the survey of the LSC to the State Fire Authority with the patterns of LSC deficiencies cited by the SAs that use State Health Department surveyors to survey the LSC. We found that each group focuses their survey efforts on structural LSC requirements (69% of the total of LSC deficiencies cited) as opposed to non-structural LSC requirements (31% of LSC deficiencies cited).

b. By contrast, the Joint Commission cited 54% of their LSC deficiencies in non-structural requirements.

CONCLUSIONS AND SUMMARY

A. Regular Sample Validation Surveys

Because regular sample validation surveys are conducted within 60 days after the accreditation survey, it was expected that the hospitals would most likely take corrective action to address the problems identified during the accreditation survey before the SA survey. If this occurred, it was expected that the SAs would identify fewer numbers of general health and safety deficiencies. The data, in fact, did indicate significant differences in the aggregate number of health and safety deficiencies cited with the Joint Commission identifying far more total numbers of general health and safety deficiencies for FY 91 and FY 92.

Accredited hospitals have few problems meeting the Medicare CoPs other than the LSC. Although the percentage of hospitals in FY 92 found out of compliance at the condition level was higher than FY 91, this is probably an anomaly resulting from the smaller sample size in FY 92. Generally, the percentage of hospitals placed under SA monitoring following regular sample validation surveys has been decreasing over the years. This continued decrease demonstrates increased equivalency between the Joint Commission and the Medicare survey processes and indicates that accreditation does, in fact, provide reasonable assurance that accredited hospitals meet Federal requirements. In addition, for the hospitals in which the SAs found condition level deficiencies during regular validation surveys, the Joint Commission did find problems in those hospitals and rendered a variety of decisions for these hospitals: accreditation with Type I recommendations (problems that must be monitored through written progress reports or onsite followup visits), conditional accreditation and nonaccreditation.

For both the FY 91 and FY 92 regular sample validation surveys, the Joint Commission identified more deficiencies than the SAs in the following deficiency type categories: Federal, State and local laws, Governing Body, Quality Assurance, Medical Staff, Nursing Services, Physical Environment and Infection Control. The emphasis on quality assurance, medical staff, infection control and the governing body's responsibility for quality assurance is consistent with the Joint Commission's program emphasis in

recent years. The SAs identified more deficiencies in the areas of Medical Records, Pharmaceutical Services, Food and Dietetic Services, Anesthesia Services, Emergency Services and Respiratory Care Services. The larger number of Pharmaceutical Services and Food and Dietetic Services deficiencies cited by the SAs during regular sample validation surveys probably reflects survey team composition in that the SAs often use pharmacists and dietitians as consultants and surveyors, whereas the Joint Commission does not.

B. 18 Month Sample Validation Surveys

FY 91 was the first year in which validation surveys were conducted 18 months into a sample of accredited hospitals' accreditation cycles. Of particular interest was how the Joint Commission accredited hospitals performed mid-way into their accreditation cycles. Analysis revealed that 33.3 percent of the sampled hospitals in FY 91 and 41.2 percent of the sampled hospitals in FY 92 were placed under SA monitoring. These percentages indicate that some accredited hospitals have trouble maintaining compliance mid-way into their accreditation cycles. In addition, 5 of the 11 hospitals with condition level deficiencies in FY 91 did not have any condition level problems 18 months earlier, and 6 of the 7 hospitals with condition level deficiencies in FY 92 did not have any condition level problems 18 months earlier according to the Joint Commission.

C. Conditional Sample Validation Surveys

For the conditional sample, validation surveys focused only on those Medicare CoPs that caused the hospital to receive a conditionally accredited decision from the Joint Commission. For this reason, it was expected that the SAs would cite less deficiencies than Joint Commission in all severity categories--conditions, standards and elements. The data confirmed this for both FY 91 and FY 92.

The Joint Commission conditionally accredited decision category seems to be a great incentive to cause hospitals to take notice and correct their problems in a timely manner. Conditional sample validation surveys in FY 91 indicate that the problems identified during accreditation surveys were corrected, except in one hospital in which the LSC was out of compliance. Conditional sample validation surveys in FY 92 indicate that the problems identified during accreditation surveys were corrected, except for two hospitals. Both of these hospitals were out of compliance with the Quality Assurance CoP and one was also out of compliance with the Medical Staff CoP.

D. Allegation Surveys

Five percent of the hospitals subject to allegation investigations in FY 92 were found to have one or more Medicare CoPs out of compliance. This percentage was the same as in FY 90. For FY 91, data showed an increase (27 percent) in the number of hospitals out of compliance with one or more Medicare CoPs. However, the number of complaint investigation surveys conducted in FY 91 was significantly lower than in FY 90 and FY 92. Because the sample size was lower in FY 91, the higher percentage does not seem to mark a trend.

E. Summary

Analysis of the Joint Commission's performance based on validation and complaint surveys for FY 91 and FY 92 indicate that, in general, Joint Commission accreditation does, in fact, provide reasonable assurance that accredited hospitals meet Federal requirements. However, there are some concerns about accredited hospitals maintaining compliance with the Medicare CoPs at the midpoint of their accreditation cycles. The analysis also leads to some specific conclusions about particular aspects of the Joint Commission's accreditation program as well as SA survey operations and HCFA's continuing oversight of these programs:

- Meeting Quality Assurance requirements is problematic for all hospitals.

- The Joint Commission, through its emphasis on continuous quality improvement activities, enforces quality assurance and infection control requirements more vigorously than the SAs. State conducted validation surveys identify more problems in Federal, State and local laws, Food and Dietetic Services, and Physical Environment with regard to Life Safety Code.

- The Joint Commission does not take enforcement action of the same intensity as the SAs. All the hospitals found out-of-compliance at the condition level during validation surveys were given termination notices, with a 90 day period of time to correct deficiencies. No final termination actions were taken, as the hospitals were able to correct the deficiencies prior to the scheduled termination date. The Joint Commission rendered a variety of decisions for hospitals with condition level deficiencies: accreditation with Type I recommendations, conditional accreditation and nonaccreditation decisions.

- The SAs have more LSC expertise and survey the LSC more vigorously than the Joint Commission.

These conclusions lead to the following actions which HCFA will pursue over future months:

- HCFA will continue to offer basic training to regional office and SA surveyors as the method of improving the survey process.

- Observation surveys of the Joint Commission accreditation process will be conducted to assess how the Joint Commission evaluates facilities for compliance with the LSC and all Medicare hospital health and safety standards. Joint surveys would eliminate the 60 day delay between the accreditation survey and the validation survey, thus improving the quality of the comparison. Joint surveys would also allow HCFA to observe first hand the investigative process the Joint Commission surveyors use to arrive at their accreditation decisions, and therefore to determine whether the Joint Commission surveyors access information that HCFA surveyors are unaware of, or vice versa.

- HCFA will observe Joint Commission surveyor training programs to provide insight into the Joint Commission decision process for Life Safety Code enforcement.

- The Joint Commission will take steps to assure that accredited hospitals maintain compliance with the Medicare CoPs throughout the entire 3 year accreditation period. *

HCFA met with representatives of the Joint Commission to present our LSC findings and discuss our LSC concerns. The Joint Commission verified that the LSC data they provided to HCFA was complete and correct.

The Joint Commission shared our concerns regarding the performance of Joint Commission LSC surveyors and has proposed to initiate the following program to improve the performance of their LSC surveyors.

- In April 1994, the Joint Commission will initiate two on-site self-validation LSC surveys per month for a period of one year. These surveys will take place shortly after the full accreditation surveys by the regular survey team in hospitals that volunteer for this effort. Accreditation decisions will not be effected by these LSC self-validation surveys. A staff engineer from the Joint Commission supervisory

staff will perform the LSC self-validation surveys. These surveys will allow the Joint Commission to evaluate the training and performance of their LSC surveyors. By July 1995, the Joint Commission will provide HCFA with a written report of the results of the LSC self-validation surveys and any recommendation which the findings might indicate.

- The Joint Commission will enhance the LSC training program for LSC hospital administrator surveyors. Effective April 1994, concerns raised by the 1991-1992 validation reports will be discussed by the Joint Commission in monthly teleconferences with its LSC surveyors, and will be addressed at quarterly meeting that are held with these surveyors throughout 1994.

- The Joint Commission will make LSC an important focus of one-week seminars that will be conducted for small groups of surveyors. The seminars will begin in the early fall of 1994 and continue through early 1995, until all surveyors surveying for LSC have attended a seminar to enhance their capability.

- The Joint Commission survey protocols are being revised for 1995. They will be field tested in May 1994, and the new protocols will be shared with surveyors in the seminars mentioned above.

The implementation of this plan for improving the Joint Commission performance of the LSC segment of the accreditation survey should begin to show measurable results in the 1995 validation surveys, which will be analyzed for inclusion in a future Report to Congress.

As an interim measure, the Joint Commission has agreed to have HCFA send representatives to observe the Joint Commission LSC surveyor training course and to observe an accreditation LSC survey. Our observations will be reported in a future Report to Congress.

HCFA also will include in a future Report to Congress the findings of the Joint Commission self-validation surveys and any further actions implemented as a result of those surveys.

HCFA and the Joint Commission continue to work in partnership to provide patients in hospitals with the maximum level of safety from fire.

* Note: In July, 1993, the Joint Commission initiated the conduct of random, unannounced surveys of accredited hospitals. An adjunct program to the traditional scheduled triennial survey, the unannounced inspections are part of the Joint Commission's increasing emphasis on day-to-day accountability and quality improvement.

FUTURE DIRECTIONS

- HCFA is initiating a project to revisit the entire process by which it assesses and validates the accreditation procedures of the Joint Commission and to make improvements where necessary. The desired end-product of this project is a new evaluation system which focuses on the complete accreditation process. Aspects of the accreditation process to be evaluated include the method by which standards are established, accuracy and efficacy of the survey process, the timeliness of survey results, the training of surveyors, the decision-making processes, the effectiveness of enforcement activities and the methods by which the Joint Commission fosters quality improvement in accredited hospitals. A two year planning and piloting process is expected, and it is hoped that the new process will be operational by December 1996.

- Effective April 1994, the Joint Commission will begin implementation of their plan for improving the LSC segment of the accreditation survey. This plan should begin to show measurable results in the 1995 validation surveys. HCFA expects no substantial change in the performance of Joint Commission LSC surveyors for 1993 and 1994. Therefore, in lieu of the traditional report on HCFA's analysis of the LSC validation survey results, we propose to report on the progress of the implementation of the Joint Commission's plan for improving the performance of Joint Commission LSC surveyors. When the 1995 LSC validation surveys are analyzed, those results will be compared to the 1991 and 1992 LSC survey results.

APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
REGION I				
Regular Sample				
22-0031 University Hospital Boston, MA	341	Accreditation w/Type I Recom.	met	--
22-0067 Quincy Hospital Quincy, MA	306	Accreditation w/Type I Recom.	met	--
22-2006 Lemuel Shattock Jamaica Plains, MA	215	Accreditation w/Type I Recom.	met	--
22-2008 Saint John of God Brighton, MA	70	Accreditation w/Type I Recom.	met	--
30-0024 Valley Regional Clarmont, NH	71	Accreditation w/Type I Recom.	met	--
41-4003 Emma-Pendleton Bradley East Providence, RI	60	Accreditation w/Type I Recom.	met	--
47-0001 Central Vermont Barre, VT	175	Accreditation w/Type I Recom.	met	--
18 Month Sample				
07-0026 Winsted Memorial Winsted, CT	17	Accreditation w/Type I Recom.	not met	PE-LSC, I
22-3300 Franciscan Children's Brighton, MA	100	Accreditation w/Type I Recom.	met	--

* "Met" indicates that the hospital met all Conditions. Standard and other requirement deficiencies may have been found.
** "Not Met" indicates that the hospital was out of compliance with one or more Conditions.

Letter Code for Conditions Out of Compliance

F - Federal, State and local laws
G - Governing Body
Q - Quality Assurance
M - Medical Staff
N - Nursing Services
P - Pharmaceutical Services
R - Radiologic Services
L - Laboratory Services
PE - Physical Environment
MR - Medical Record Services
FD - Food and Dietetic Services
I - Infection Control
S - Surgical Services
LSC - Life Safety Code
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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
30-0018 Wentworth-Douglas Dover, NH	178	Accreditation w/Type I Recom.	met	--
REGION II				
Regular Sample				
31-0029 Our Lady of Lordes Camden, NJ	375	Accreditation w/Type I Recom.	met	--
31-0034 Riverview Medical Center Red Bank, NJ	492	Accreditation w/Type I Recom.	met	--
33-0001 Horton Memorial Middletown, NY	286	Accreditation w/Type I Recom.	met	--
33-0006 St. Josephs Yonkers, NY	194	Accreditation w/Type I Recom.	met	--
33-0023 Vassar Brothers Hospital Poughkeepsie, NY	300	Accreditation w/Type I Recom.	met	--
33-0034 Union Hospital New York, NY	201	Accreditation w/Type I Recom.	met	--
33-0039 Cuba Memorial Cuba, NY	26	Accreditation w/Type I Recom.	met	--
33-0239 Woman's Christian Jamestown, NY	337	Accreditation w/Type I Recom.	not met	F, I
33-0395 St. John's Episcopal Far Rockaway	614	Accreditation w/Type I Recom.	met	--

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
40-0001 Ashford Presbyterian Santurce, PR	207	Accreditation w/Type I Recom.	not met	G, L, RC
40-0106 Metropolitan San Juan, PR	180	Accreditation w/Type I Recom.	not met	G, N, P, FD I, E, RC
18 Month Sample				
33-0078 Sistars of Charity Hospital Buffalo, NY	436	Accreditation w/Type I Recom.	met	--
33-0151 St. James Mercy Hornell, NY	155	Accreditation w/Type I Recom.	met	--
33-0277 Corning Hospital Corning, NY	154	Accreditation w/Type I Recom.	met	--
Conditional Sample				
31-0054 Mountainside Montclair, NJ	469	Conditional	met	--
33-0252 Elizabethtown Community Elizabethtown, NY	25	Conditional	met	--
33-0396 Woodhull Memorial Brooklyn, NY	499	Conditional	met	--
33-2021 Monroe Community Rochester, NY	39	Conditional	met	--

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N - Nursing Services	I - Infection Control	RS - Rehabilitation Services
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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
REGION III				
Regular Sample				
21-0022 Suburban Hospital Bethesda, MD	338	Accreditation w/Commendation	met	--
21-0037 Memorial Hospital Easton, MD	214	Accreditation w/Type I Recom.	met	--
21-2003 Dear's Head Salisbury, MD	188	Accreditation w/Type I Recom.	met	--
39-0081 Delaware County Memorial Drexel Hill, PA	215	Accreditation w/Type I Recom.	not met	PE-LSC
39-0125 Wayne Memorial Honesdale, PA	76	Accreditation w/Type I Recom.	met	--
39-0204 Nazareth Hospital Philadelphia, PA	385	Accreditation w/Type I Recom.	not met	PE-LSC
39-0225 Ephrata Community Ephrata, PA	105	Accreditation w/Type I Recom.	not met	PE-LSC
39-3033 Moss Rehabilitation Hosp Philadelphia, PA	152	Accreditation w/Type I Recom.	not met	PE-LSC
39-4034 The Horsham Clinic Ambler, PA	128	Accreditation w/Type I Recom.	not met	LSC
49-0047 Page Memorial Luray, VA	54	Accreditation w/Type I Recom.	met	--

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M - Medical Staff	FD - Food and Dietetic Services	E - Emergency Services
N - Nursing Services	I - Infection Control	RS - Rehabilitation Services
P - Pharmaceutical Services	S - Surgical Services	RC - Respiratory Care
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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
49-0066 Williamsburg Community Williamsburg, VA	139	Accreditation w/Commendation	not met	LSC
49-0069 Richmond Memorial Valley Richmond, VA	420	Accreditation w/Type I Recom.	met	--
49-4017 South VA Mental Health Danville, VA	96	Accreditation w/Type I Recom.	not met	PE-LSC
51-0024 Monongalia General Morgantown, WV	254	Accreditation w/Type I Recom.	met	--
51-0070 HCA Raleigh General Beckley, WV	275	Accreditation w/Type I Recom.	met	--
51-0077 Williamson Memorial Williamson, WV	76	Accreditation w/Type I Recom.	not met	L
51-0126 Southern Hills Regional Princeton, WV	40	Accreditation w/Type I Recom.	met	--
18 Month Sample				
21-0059 Liberty Medical Ctr Baltimore, MD	282	Accreditation	met	--
39-0006 Geisinger Medical Ctr Danville, PA	577	Accreditation w/Type I Recom.	not met	PE-LSC
39-0067 Polyclinic Med Ctr Harrisburg, PA	350	Accreditation w/Type I Recom.	not met	PE-LSC

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
39-0146 Warren General Warren, PA	71	Accreditation w/Type I Recom.	not met	LSC
39-0246 Charles Cole Coudersport, PA	61	Accreditation w/Type I Recom.	not met	PE
REGION IV				
Regular Sample				
01-0046 Holy Name of Jesus Medical Gadsden, AL	281	Accreditation w/Type I Recom.	met	--
01-0061 Jackson County Hospital Scottsboro, AL	170	Accreditation w/Type I Recom.	met	--
01-0068 Lloyd Noland Hospital Fairfield, AL	319	Accreditation w/Type I Recom.	not met	LSC
01-0086 Winfield Carraway Winfield, AL	71	Accreditation w/Type I Recom.	met	--
10-0016 Clay Memorial Green Cove Springs, FL	60	Nonaccreditation (Failed Followup)	met	--
10-0051 South Lake Memorial Clermont, FL	18	Accreditation w/Type I Recom.	met	--
10-0084 Leesburg Regional Medical Leesburg, FL	294	Accreditation w/Type I Recom.	met	--
10-0099 Lake Whales Lake Whales, FL	154	Accreditation w/Type I Recom.	met	--

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
10-0103 Bradford Hospital Starke, FL	54	Accreditation w/Type I Recom.	met	--
10-0124 Santa Rosa Med Ctr Milton, FL	153	Accreditation w/Type I Recom.	met	--
10-0146 Suwannee Hospital Live Oak, FL	24	Accreditation w/Type I Recom.	met	--
10-0161 HCA Central FL Regional Sanford, FL	226	Accreditation	met	--
10-0169 Memorial Hospital Ormond Ormond Beach, FL	205	Accreditation w/Type I Recom.	met	--
10-0211 Humana Hospital Pasco Dade City, FL	120	Accreditation w/Commendation	met	--
10-0225 Hollywood Medical Center Hollywood, FL	334	Accreditation w/Type I Recom.	met	--
10-4011 Lake of the Palm Lake Worth, FL	98	Accreditation w/Type I Recom.	met	--
11-0002 Upson Regional Medical Thomaston, GA	119	Accreditation w/Type I Recom.	met	--
11-0201 Charter-Northside Macon, GA	103	Accreditation w/Type I Recom.	met	--
11-0026 Elbart Memorial Elbarton, GA	52	Accreditation w/Type I Recom.	met	--

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
11-0172 Shallowford Community Dunwoody, GA	178	Accreditation w/Commendation	not met	LSC
18-0019 Meadowview Regional Maysville, KY	111	Accreditation w/Type I Recom.	met	--
18-0040 Jewish Hospital, Inc. Louisville, KY	493	Accreditation w/Type I Recom.	met	--
18-0046 Bourbon General Paris, KY	58	Accreditation w/Type I Recom.	met	--
18-4011 Chartar Hospital Paducah Paducah, KY	80	Accreditation w/Type I Recom.	not met	LSC
18-4015 Central State Hospital Louisville, KY	192	Accreditation w/Type I Recom.	met	--
25-0057 Kings Daughters Hospital Brookhaven, MS	122	Accreditation w/Type I Recom.	met	--
34-0001 Cabarrus Memorial Hospital Comcord, NC	458	Accreditation w/Type I Recom.	met	--
34-0032 Gaston Memorial Hospital Gastonia, NC	436	Accreditation w/Type I Recom.	met	--
34-0123 Randolph Hospital Asheboro, NC	145	Accreditation w/Type I Recom.	not met	PE-LSC
34-0132 Maria Parham Henderson, NC	100	Accreditation w/Type I Recom.	met	--

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APPENDIX A

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JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
34-0144 Davis Community Hospital Statesville, NC	149	Accreditation w/Type I Recom.	not met	PE
34-0158 Brunswick Supply, NC	49	Accreditation w/Type I Recom.	met	--
42-0002 Piedmont Medical Center Rock, Hill, SC	271	Accreditation w/Type I Recom.	met	--
42-0042 Mullins Mullins, SC	80	Accreditation w/Type I Recom.	met	--
42-0082 HCA Aiken Reg Med Ctr Aiken, SC	190	Accreditation w/Type I Recom.	met	--
44-0052 Scott County Oneida, TN	99	Accreditation w/Type I Recom.	met	--
44-0063 Johnson City Med Ctr Johnson City, TN	407	Accreditation w/Type I Recom.	met	--
44-0064 South Pittsburg Municipal South Pittsburg, TN	100	Accreditation w/Type I Recom.	met	--
44-0068 HCA Athens Community Athens, TN	118	Accreditation w/Type I Recom.	met	--
44-0184 Northside Johnson City, TN	55	Accreditation w/Type I Recom.	met	--
44-0200 Stones River Woodbury, TN	46	Accreditation w/Type I Recom.	met	--

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
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227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
44-4001 Memphis Mental Health Memphis, TN	211	Accreditation w/Type I Recom.	met	--
18 Month Sample				
10-0228 Humana-Bennett Plantation, FL	204	Accreditation w/Type I Recom.	not met	G, P
11-0193 Newnan Hospital Newnan, GA	110	Accreditation w/Type I Recom.	not met	LSC
Conditional Sample				
01-4001 Charter Retreat Decatur, AL	64	Conditional	not met	LSC
10-0044 Martin Memorial Stuart, FL	336	Conditional	met	--
18-0026 Marshall County Benton, KY	46	Conditional	met	--
REGION V				
Regular Sample				
14-0051 Rush North Shore Medical Skokie, IL	284	Accrediation w/Type I Recom.	not met	LSC
14-0097 Hoopeston Community Hoopeston, IL	38	Accreditation w/Type I Recom.	met	--

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FY 91 SAMPLE VALIDATION SURVEYS
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14-0160 Freeport Memorial Hospital Freeport, IL	253	Accreditation w/Type I Recom.	met	--
14-0250 South Suburban Hospital Hazal Crest, IL	245	Accreditation w/Commendation	not met	S
15-0009 Clark Memorial Jeffersonvills, IN	285	Accreditation w/Type I Recom.	met	--
15-0061 Daviess Community Washington, IN	136	Accreditation w/Type I Recom.	not met	LSC
15-0095 Pulaski Memorial Winamac, IN	52	Accreditation w/Type I Recom.	not met	PE-LSC
15-0136 Humana Women's Hospital Indianapolis, IN	182	Accreditation w/Type I Recom.	met	--
23-0043 Battle Creek Adventist Battle Creek, MI	155	Accreditation w/Type I Recom.	met	--
23-0059 St. Mary's Health Ctr Grand Rapids, MI	310	Accreditation w/Type I Recom.	not met	A
23-0090 Doctor's Hospital Detroit, MI	101	Nonaccreditation (Failed Followup)	met	--
23-0223 Oakland General Hospital Madison Heights, MI	261	Accreditation w/Type I Recom.	met	--
23-0254 Crittenton Hospital Rochester, MI	290	Accreditation w/Type I Recom.	met	--

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APPENDIX A

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HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
23-4006 Pine Rest Christian Grand Rapids, MI	146	Accreditation w/Commendation	not met	FD, PE-LSC
36-0009 Lima Memorial Lima, OH	285	Accreditation w/Type I Recom.	met	--
36-0026 Greene Memorial Xenia, OH	235	Accreditation w/Type I Recom.	met	--
36-0109 Coshocton County Memorial Coshocton, OH	110	Accreditation w/Type I Recom.	met	--
36-0112 St. Vincent Med Ctr Toledo, OH	621	Accreditation w/Type I Recom.	met	--
36-0153 City Hospital Bellaire, OH	129	Accreditation w/Type I Recom.	not met	LSC
36-4001 Cleveland Psychiatric Cleveland, OH	226	Accreditation w/Type I Recom.	met	--
52-0015 Good Samaritan Hlth Ctr Marrill, WI	73	Accreditation w/Type I Recom.	met	--
52-0028 St. Clare Monroe, WI	100	Accreditation w/Type I Recom.	not met	LSC
52-0045 Theda Clark Regional Neenah, WI	386	Accreditation w/Type I Recom.	not met	LSC
52-0113 Bay Area Medical Center Marinette, WI	99	Accreditation w/Type I Recom.	met	--

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18 Month Sample				
14-0088 University of Chicago Chicago, IL	673	Accreditation w/Type I Recom.	met	--
14-4029 Carle Pavillion Champaigne, IL	46	Accreditation w/Type I Recom.	met	--
15-0013 Mary Sherman Hospital Sullivan, IN	100	Accreditation w/Type I Recom.	met	--
23-0108 Portage View Hancock, MI	93	Accreditation w/Type I Recom.	met	--
24-4008 Brainard Brainard, MN	124	Accreditation w/Type I Recom.	met	--
36-0106 Hocking Valley Community Logan, OH	92	Accreditation w/Type I Recom.	not met	PE-LSC
52-0077 Oconto Memorial Oconto, WI	40	Nonaccreditation (Failed Followup)	not met	I, LSC
Conditional Sample				
23-0115 Schoolcraft Memorial Manistique, MI	47	Conditional	met	--
24-0170 Granite Falls Granite Falls, MN	30	Conditional	met	--
52-0003 Myrtle Warth Medical Menomonie, WI	63	Conditional	met	--

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
REGION VI				
Regular Sample				
04-0001 Siloam Springs Siloam Springs, AR	73	Accreditation w/Type I Recom.	met	--
04-0020 St Bernards Regional Jonesboro, AR	375	Accreditation w/Type I Recom.	met	--
04-0021 Southwest Hospital Little Rock, AR	97	Accreditation w/Type I Recom.	met	--
04-0119 White River Medical Batesville, AR	152	Accreditation w/Type I Recom.	met	--
19-0099 Humana Hospital Marksville Marksville, LA	55	Accreditation w/Commendation	met	--
19-0158 St Charles General Hospital New Orleans, LA	173	Accreditation w/Type I Recom.	met	--
19-4006 CPC Coliseum Medical New Orleans, LA	168	Accreditation w/Type I Recom.	met	--
19-4007 Southeast LA Hospital Mandeville, LA	421	Accreditation w/Type I Recom.	met	--
19-4020 Charter Forest Shreveport, LA	83	Accreditation w/Type I Recom.	met	--
19-4021 CPC Meadowood Baton Rouge, LA	85	Accreditation w/Type I Recom.	met	--

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
32-0001 University of New Mexico Albuquerque, NM	421	Accreditation w/Type I Recom.	met	--
32-0006 Eastern New Mexico Medical Roswell, NM	220	Accreditation w/Type I Recom.	met	--
37-0025 Muskogee Memorial Medical Muskogee, OK	366	Accreditation w/Type I Recom.	met	--
37-0033 Bartlett Memorial Medical Sapulpa, OK	113	Accreditation w/Commendation	met	--
37-0034 McAlester Regional McAlester, OK	200	Accreditation w/Type I Recom.	met	--
37-0057 Okmulgee Memorial Hospital Okmulgee, OK	66	Accreditation	met	--
37-0183 Henryetta Henryetta, OK	52	Accreditation w/Type I Recom.	met	--
37-4003 Willow View Spencer, OK	93	Accreditation w/Type I Recom.	met	--
45-0004 Linden Municipal Linden, TX	49	Accreditation w/Type I Recom.	not met	A
45-0018 Univ. of Texas Med Branch Galveston, TX	740	Accreditation w/Type I Recom.	met	--
45-0024 RE Thomason General El Paso, TX	208	Accreditation w/Commendation	met	--

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
45-0047 Dolly Vinsant San Benito, TX	64	Accreditation w/Type I Recom.	met	--
45-0165 Tri-City Community Hospital Jourdanton, TX	30	Accreditation w/Type I Recom.	met	--
45-0192 Hill Regional Hillsboro, TX	75	Accreditation w/Type I Recom.	not met	Q, P, L
45-0288 Deleon Hospital Deleon, TX	34	Accreditation w/Type I Recom.	met	--
45-0324 Texoma Medical Center Denison, TX	211	Accreditation w/Type I Recom.	not met	Q, P
45-0646 Vista Hills Med Ctr El Paso, TX	179	Accreditation w/Commendation	met	--
45-4007 HCA-Beaumont Neuro Beaumont, TX	76	Accreditation w/Type I Recom.	met	--
45-4032 HCA Brazos Psychiatric Waco, TX	36	Accreditation w/Type I Recom.	met	--
45-4062 Twin Lakes Hospital Denton, TX	104	Nonaccreditation (Failed Followup)	not met	Q, L, E
45-0571 Shannon Medical Center San Angelo, TX	160	Accreditation w/Type I Recom.	met	--
45-0584 Wilbarger General Hospital Vernon, TX	42	Accreditation w/Type I Recom.	met	--

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
45-0597 Cuero Community Hospital Cuero, TX	49	Accreditation w/Type I Recom.	met	--
45-0638 Houston Northwest Medical Houston, TX	439	Accreditation w/Type I Recom.	met	--
18 Month Sample				
32-0005 San Juan Regional Farmington, NM	126	Accreditation w/Type I Recom.	met	--
32-0017 St. Joseph's Northeast Albuquerque, NM	120	Accreditation w/Type I Recom.	met	--
37-1300 J D McCarty Center Norman, OK	60	Accreditation w/Type I Recom.	met	--
45-0674 Woman's Hosp. of Texas Houston, TX	198	Accreditation w/Type I Recom.	met	--
Conditional Sample				
19-0120 Prevost Memorial Hospital Donaldsonville, LA	35	Conditional	met	--
19-4016 Jo Ellen Smith Psychistric New Orleans, LA	75	Conditional	met	--

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
REGION VII				
Regular Sample				
16-0024 Iowa Lutheran Des Moines, IA	437	Accreditation w/Type I Recom.	met	--
17-0027 Pratt Regional Medical Pratt, KS	29	Accreditation w/Type I Recom.	met	--
17-0103 Newton Healthcare Corp Newton, KS	150	Accreditation w/Type I Recom.	met	--
26-0014 Barnes Hospital St. Louis, MO	1208	Accreditation w/Type I Recom.	met	--
26-0018 St. Francis Mountainview, MO	42	Conditional	met	--
26-0040 Lester E. Cox Medical Springfield, MO	780	Accreditation w/Type I Recom.	met	--
26-0068 Boone Hospital Center Columbia, MO	325	Accreditation w/Type I Recom.	met	--
26-0112 Menorah Med Ctr Kansas City, MO	430	Accreditation w/Type I Recom.	met	--
26-2001 MO Rehabilitation Mount Vernon, MO	101	Accreditation w/Type I Recom.	not met	Q
26-4021 North Hills Hospital Kansas City, MO	76	Accreditation w/Type I Recom.	met	--

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
28-0013 Univ. of Nebraska Med Ctr Omaha, NE	352	Accreditation w/Type I Recom.	met	--
18 Month Sample				
16-0030 Mary Greeley Ames, IA	197	Accreditation w/Type I Recom.	met	--
Conditional Sample				
16-0062 DeWitt Community Hospital DeWitt, IA	30	Conditional	met	--
REGION VIII				
Regular Sample				
06-0010 Poudre Valley Hospital Fort Collins, CO	235	Accreditation w/Type I Recom.	not met	P, PE-LSC
06-0044 Colorado Plains Med Ctr Fort Morgan, CO	40	Accreditation w/Type I Recom.	met	--
06-0068 East Morgan County Hospital Brush, CO	29	Accreditation w/Type I Recom.	met	--
06-0076 Sterling Regional MedCenter Sterling, CO	36	Accreditation w/Type I Recom.	met	--
27-0014 St. Patrick Missoula, MT	195	Accreditation w/Type I Recom.	not met	LSC

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
35-0041 Community Memorial Hospital Lisbon, ND	25	Accreditation w/Type I Recom.	met	--
46-0001 Utah Valley Regional Med Provo, UT	395	Accreditation w/Type I Recom.	met	--
46-0021 Dixie Medical Center St George, UT	106	Accreditation w/Type I Recom.	met	--
53-0018 Community Hospital Torrington, WY	53	Accreditation w/Type I Recom.	not met	Q, M, I
18 Month Sample				
35-0030 Mercy Hospital Devils Lake, ND	110	Conditional	met	--
46-4003 Charter Canyon Orem, UT	62	Accreditation w/Type I Recom.	met	--
Conditional Sample				
06-0033 Mount San Rafael Trinidad, CO	70	Conditional	met	--
06-0062 Lincoln Community Hospital Hugo, CO	21	Conditional	met	--

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FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
REGION IX				
Regular Sample				
03-0011 St. Josepha Tucson, AZ	302	Accreditation w/Type I Recom.	met	--
03-0013 Yuma Regional Yuma, AZ	283	Accreditation	met	--
03-0036 Chandler Regional Hospital Chandler, AZ	120	Accreditation w/Type I Recom.	met	--
03-0085 Northwest Hospital Tucson, AZ	116	Accreditation w/Type I Recom.	met	--
05-0077 Mercy Hospital and Medical San Diego, CA	501	Accreditation w/Type I Recom.	met	--
05-0242 Dominican Santa Cruz Santa, Crus, CA	380	Accreditation w/Type I Recom.	met	--
05-0267 Daniel Freeman Inglewood, CA	403	Accreditation w/Type I Recom.	met	--
05-0317 Pioneer Hospital Artesia, CA	99	Accreditation w/Type I Recom.	not met	PE-LSC
05-0486 Bellwood General Hospital Bellflower, CA	85	Accreditation w/Type I Recom.	not met	PE-LSC
05-4092 Woodside Women's Redwood City, CA	27	Accreditation w/Type I Recom.	met	--

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Letter Code for Conditions Out of Compliance

F - Federal, State and local laws	L - Laboratory Services	A - Anesthesia Services
G - Governing Body	PE - Physical Environment	NM - Nuclear Medicine
Q - Quality Assurance	MR - Medical Record Services	O - Outpatient Services
M - Medical Staff	FD - Food and Dietatic Services	E - Emergency Services
N - Nursing Services	I - Infection Control	RS - Rehabilitation Services
P - Pharmaceutical Services	S - Surgical Services	RC - Respiratory Care
R - Radiologic Services	LSC - Life Safety Code	

APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
05-0526 Humana Hospital Huntington Huntington Beach, CA	141	Accreditation w/Type I Recom.	met	--
05-0586 Chino Community Hospital Chino, CA	118	Accreditation w/Type I Recom.	met	--
12-0001 Queens Medical Ctr Honolulu, HI	506	Accreditation w/Type I Recom.	met	--
18 Month Sample				
05-0260 Mountains Community Lake Arrowhead, CA	37	Conditional	met	--
05-0450 Mono General Bridgeport, CA	5	Nonaccreditation (Failed Followup)	not met	L
05-0510 Kaiser Foundation Hospital San Rafael, CA	120	Accreditation w/Type I Recom.	not met	PE
Conditional Sample				
05-0222 Community of Chula Vista Chula Vista, CA	100	Conditional	met	--
05-0327 Loma Linda Univ. Med Ctr Loma Linda, CA	627	Conditional	met	--
REGION X				
13-4002 CPC Intermountain Hospital Boise, ID	95	Accreditation w/Type I Recom.	met	--

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FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
13-4005 River Crest Lewiston, ID	46	Accreditation w/Type I Recom.	met	--
38-0063 Southern Oregon Med Ctr Grants Pass, OR	63	Accreditation w/Type I Recom.	met	--
38-0071 McMinnville Community McMinnville, OR	80	Accreditation w/Type I Recom.	met	--
38-0091 Kaiser Sunnyside Med Ctr Clackamus, OR	196	Accreditation	met	--
50-0033 Samaritan Hospital Moses Lake, WA	50	Accreditation w/Type I Recom.	met	--
50-0077 Holy Family Spokane, WA	272	Accreditation w/Type I Recom.	met	--
50-0135 Snoqualmie Valley Hospital Snoqualmie, WA	28	Nonaccreditation (Failed Followup)	not met	F, G, Q
50-4002 CPC Fairfax Hospital Kirkland, WA	133	Accreditation w/Commendation	met	--
18 Month Sample				
38-0018 Rogue Valley Medford, OR	305	Accreditation w/Type I Recom.	met	--
50-0003 Skagitt Valley Mount Vernon, WA	234	Accreditation w/Type I Recom.	met	--

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APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
50-4003 Western State Hospital Fort Steilacoom, WA	984	Accreditation w/Type I Recom.	met	--

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APPENDIX B

REGULAR SAMPLE
SAMPLE VALIDATION SURVEYS - VALIDATION DECISIONS
BY SURVEY PERIOD
(n = 177)

	FY 1990		FY 1991		ALL PREVIOUS REPORT PERIODS (INCLUDING FY 90)	
VALIDATION SURVEY DECISIONS	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals in compliance	144	74.2	141	79.7	810	54.9
Hospitals out of compliance	50	25.8	36	20.3	665	45.1
TOTAL SURVEYS PERFORMED	194	100.0	177	100.0	1475	100.0

REASONS FOR NONCOMPLIANCE	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals out of compliance with Life Safety Code only	11	22.0	11	30.6	313	49.1
Hospitals out of compliance with Life Safety Code and at least one Condition of Participation	11	22.0	11	30.6	176	26.8
Hospitals out of compliance for reasons other than Life Safety Code	28	56.0	14	38.8	176	24.1
TOTAL	50	100.0	36	100.0	665	100.0

APPENDIX C

FY 91 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE
45 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
REGION I					
20-0034 St Mary's General	233	09/06/91	10/22/91	12/01/91	Q
22-0074 Tobey Hospital	86	08/13/91	09/30/91	10/07/91	Q, P
REGION II					
None					
REGION III					
21-4010 Gundrey-Glass Hosp	85	02/15/91	03/01/91	03/05/91	Q, M
39-0067 Polyclinic Medical	350	07/18/91	09/25/91	12/31/91	PE (LSC)
51-0002 Humana Greenbrier	122	03/21/91	03/21/91	04/22/91	F, L
REGION IV					
10-0001 University Med Ctr	485	11/01/91	11/14/91	01/31/92	PE
11-0093 Patterson Hospital	40	04/04/91	04/08/91	06/27/91	E
11-0143 Cobb Hospital	333	04/11/91	04/11/91	05/13/91	MR
11-0185 Charlton Memorial	50	05/07/91	05/07/91	07/18/91	G, M, A, E
18-0006 Jenkins Community	60	07/31/91	08/09/91	10/28/91	G, Q, M, N
25-0068 Claiborne County	32	01/15/91	02/22/91	03/15/91	G, E
44-0125 Fort Sanders Reg Med	575	11/14/91	11/14/91	12/05/91	M

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M - Medical Staff	FD - Food and Dietetic Services	E - Emergency Services
N - Nursing Services	I - Infection Control	RS - Rehabilitation Services
P - Pharmaceutical Services	S - Surgical Services	RC - Respiratory Care Services
R - Radiologic Services	LSC - Life Safety Code	FT - Fatal Transfusion

APPENDIX C

FY 91 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE
45 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
44-0132 Henry County Gen	142	09/18/91	09/23/91	10/19/91	E, M
44-0143 Lewisburg Comm	119	07/08/91	07/08/91	09/10/91	N, I, S
REGION V					
14-0001 Graham Hospital	100	03/25/91	03/26/91	05/07/91	E
14-0018 Mt Sinai Hosp	445	02/07/91	02/08/91	07/30/91	M, E
14-0032 St. Anthony's Memorial	146	11/01/91	11/15/91	12/30/91	M, E
14-0077 Centreville Township	189	12/13/91	03/09/91	Terminated 12/07/92	PE
14-0119 Rush-Presbyterian	1044	05/01/91	05/01/91	07/10/91	N, I
14-0132 Illinois Masonic	542	07/11/91	08/13/91	10/08/91	P, FD, PE ,I, S
14-0152 Bethany Hospital	204	09/11/91	10/09/91	12/01/91	M
14-2006 Vencor Hospital	106	10/24/91	11/04/91	12/30/91	N
14-0223 Lutheran General	712	05/22/91	07/01/91	11/13/91	I
14-0223 Lutheran General	712	08/14/91	09/09/91	11/13/91	PE
23-0077 St. Mary's Med	261	08/02/91	08/23/91	10/11/91	PE
23-0230 Edward W. Sparrow	502	12/05/91	01/03/92	03/01/92	I
24-0080 Riverside Med	1,072	06/25/91	06/28/91	09/25/91	I
36-0057 Twin City Hospital	70	07/11/91	09/03/91	10/08/91	Q, MR, I, S

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P - Pharmaceutical Services	S - Surgical Services	RC - Respiratory Care Services
R - Radiologic Services	LSC - Life Safety Code	FT - Fatal Transfusion

APPENDIX C

FY 91 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE
45 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
REGION VI					
45-0034 St. Elizabeth Hosp	497	02/21/91	02/27/91	03/15/91	P
45-0037 Good Shepherd Med	229	02/14/91	02/28/91	03/31/91	Q
45-0518 Park Place Hosp	195	07/17/91	07/17/91	09/01/91	Q, P
45-3047 Plano Rehab	60	08/01/91	08/15/91	10/15/91	Q, N, A
45-0620 Dimmit County Mem	32	04/29/91	07/10/91	07/22/91	F, Q
45-0662 Valley Regional	138	12/01/91	12/23/91	02/01/92	G, Q, M, MR
45-0684 Northeast Med Ctr	195	01/24/91	01/24/91	02/21/91	Q, RC
REGION VII					
26-0146 Ellis Fischel Cancer	68	08/05/91	08/27/91	09/30/91	G
REGION VIII					
06-0104 St Anthony Hosp	216	10/11/91	12/28/90	04/24/91	F, PE
REGION IX					
05-0281 Alhambra	115	11/18/91	11/25/91	03/11/92	E
05-0425 Kaiser Foundation	324	08/09/91	10/23/91	11/20/91	I
05-0531 Bellflower Hosp	163	09/05/91	09/15/91	11/30/91	Q, M
05-0577 Santa Marta Hosp	110	07/17/91	07/29/91	10/16/91	Q, M, A

Letter Code for Conditions Out of Compliance

F - Federal, State and Local Laws	L - Laboratory Services	A - Anesthesia Services
G - Governing Body	PE - Physical Environment	NM - Nuclear Medicine
Q - Quality Assurance	MR - Medical Record Services	O - Outpatient Services
M - Medical Staff	FD - Food and Dietetic Services	E - Emergency Services
N - Nursing Services	I - Infection Control	RS - Rehabilitation Services
P - Pharmaceutical Services	S - Surgical Services	RC - Respiratory Care Services
R - Radiologic Services	LSC - Life Safety Code	FT - Fatal Transfusion

APPENDIX C

FY 91 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE
45 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
05-0681 San Vicente Hosp	17	10/01/91	10/08/91	12/15/91	Q, M
05-4044 CPC Santa Ana Psych	52	01/03/91	01/11/91	03/15/91	Q
REGION X					
38-0023 Good Shepherd	49	02/07/91	03/11/91	04/29/91	I
38-0036 Cottage Grove	31	02/28/91	03/26/91	04/29/91	F

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M - Medical Staff	FD - Food and Dietetic Services	E - Emergency Services
N - Nursing Services	I - Infection Control	RS - Rehabilitation Services
P - Pharmaceutical Services	S - Surgical Services	RC - Respiratory Care Services
R - Radiologic Services	LSC - Life Safety Code	FT - Fatal Transfusion

APPENDIX D

ALLEGATION INVESTIGATION SURVEYS
COMPLIANCE AND NONCOMPLIANCE DECISIONS

ALLEGATION INVESTIGATION SURVEY DECISIONS	FY 1990 NUMBER	FY 1990 PERCENT	FY 1991 NUMBER	FY 1991 PERCENT
Hospitals in compliance	660	95	105	70
Hospitals out of compliance	35	5	45	30
Surveys performed	695	100	150	100

REASONS FOR NONCOMPLIANCE	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals out of compliance with Life Safety Code only	2	6	0	0
Hospitals out of compliance with Life Safety Code and at least one Condition of Participation	1	3	1	2
Hospitals out of compliance for reasons other than Life Safety Code	32	91	44	98
TOTAL	35	100	45	100

APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
REGION I				
Regular Sample				
07-0005 Waterbury Hospital Waterbury, CT	405	Accreditation w/Type I Recom.	met	--
07-0006 Stamford Hospital Stamford, CT	383	Accreditation w/Type I Recom.	not met	PE-LSC
20-0019 Southern Maine Med Ctr Biddeford, ME	150	Accreditation w/Type I Recom.	met	--
20-0027 Down East Community Machias, ME	38	Accreditation w/Type I Recom.	met	--
22-0019 Harrington Memorial Southbridge, MA	119	Accreditation w/Type I Recom.	met	--
22-0107 Hillcrest Hospital, Inc. Pittsfield, MA	97	Accreditation w/Type I Recom.	not met	Q
22-0110 Brigham & Womens Hospital Boston, MA	726	Accreditation w/Type I Recom.	met	--
47-0015 Mt. Ascutney Windsor, VT	33	Accreditation w/Type I Recom.	met	--
18 Month Sample				
22-0098 Nashoba Community Ayer, MA	63	Accreditation w/Type I Recom.	met	--

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S - Surgical Services
LSC - Life Safety Code
A - Anesthesia Services
NM - Nuclear Medicine
O - Outpatient Services
E - Emergency Services
RS - Rehabilitation Services
RC - Respiratory Care

APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
22-0102 St. Margarets Hospital for Women Dorchester, MA	99	Accreditation w/Type I Recom.	met	--
30-0019 Cheshire Med Ctr Keene, NH	173	Accreditation w/Type I Recom.	not met	PE
410012 Miriam Hospital Providence, RI	247	Accreditation w/Type I Recom.	met	--
REGION II Regular Sample				
31-0042 West Hudson Kearny, NJ	172	Accreditation w/Type I Recom.	met	--
31-0043 Montclaire Community Montclaire, NJ	117	Accreditation w/Type I Recom.	met	--
31-0049 St. Francis Community Health Jersey City, NJ	254	Accreditation w/Type I Recom.	met	--
33-0047 St. Mary's Hospital Amsterdam, NY	149	Accreditation w/Type I Recom.	met	--
33-0055 Booth Memorial Med Ctr Flushing, NY	487	Accreditation w/Type I Recom.	not met	LSC
33-0103 Olean General Olean, NY	264	Accreditation w/Type I Recom.	not met	LSC

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APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
33-0119 Lenox Hill New York, NY	652	Accreditation w/Type I Recom.	not met	LSC
33-0184 New Rochelle Hospital New Rochelle, NY	311	Accreditation w/Type I Recom.	met	--
33-0357 Catholic Med Ctr Jamaica, NY	1140	Accreditation	not met	I
33-4017 Middletown Psychiatric Middletown, NY	573	Accreditation	not met	LSC
18 Month Sample				
33-0065 Niagra Falls Memorial Niagra Falls, NY	322	Accreditation w/Type I Recom.	not met	FD, LSC
Conditional Sample				
33-0114 Edward John Nobel Alexander Bay, NY	24	Conditional	not met	Q, M
REGION III				
Regular Sample				
21-0018 Montgomery General Olney, MD	213	Accreditation w/Type I Recom.	met	--
21-0033 Carroll County General Westminster, MD	148	Accreditation w/Type I Recom.	not met	MR

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S - Surgical Services
LSC - Life Safety Code
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RS - Rehabilitation Services
RC - Respiratory Care

APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
21-0051 Doctor's Community Lanham, MD	250	Accreditation w/Type I Recom.	met	--
39-0014 Seidle Memorial Mechanicsburg, PA	15	Accreditation w/Type I Recom.	not met	PE-LSC
39-0042 Washington Hospital Washington, PA	308	Accreditation w/Type I Recom.	met	--
39-0072 Berwick Healthcare Berwick, PA	137	Conditional	not met	PE-LSC
39-0075 Divine Providence Williamsport, PA	181	Accreditation w/Type I Recom.	not met	PE-LSC
39-0088 Germantown Med Ctr Philadelphia, PA	237	Accreditation w/Commendation	not met	PE-LSC
39-0127 Phoenixville Phoenixville, PA	131	Accreditation w/Type I Recom.	not met	PE-LSC
39-0156 Mercy Catholic Medical Darby, PA	292	Accreditation w/Type I Recom.	not met	PE-LSC
39-0195 Lankenau Hospital Philadelphia, PA	475	Accreditation w/Type I Recom.	not met	PE-LSC
39-0277 Mount Sinai Hospital Philadelphia, PA	150	Accreditation w/Type I Recom.	not met	PE-LSC
39-0256 Harshey Medical Center- University Hospital Harshey, PA	364	Accreditation w/Type I Recom.	not met	PE-LSC

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APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
51-0039 Ohio Valley Med Ctr Wheeling, WV	453	Accreditation w/Type I Recom.	met	--
REGION IV				
Regular Sample				
01-0125 Burwick-West Memorial Haleyville, AL	110	Accreditation w/Type I Recom.	not met	LSC
01-0131 Crestwood Hospital Huntsville, AL	120	Accreditation w/Type I Recom.	met	--
01-0139 AMI Brookwood Hospital Birmingham, AL	586	Accreditation w/Type I Recom.	met	--
01-0006 Eliza Coffee Memorial Florence, AL	372	Accreditation w/Type I Recom.	met	--
10-0009 Cedars Med Ctr Miami, FL	585	Accreditation w/Type I Recom.	met	--
10-0045 West Volusia Memorial DeLand, FL	162	Accreditation w/Type I Recom.	met	--
10-0126 Palms of Pasadena St. Petersburg, FL	310	Accreditation w/Type I Recom.	met	--
10-0156 Lake City Med Ctr Lake City, FL	75	Accreditation w/Type I Recom.	met	--
10-0236 Fawcett Memorial Port Charlotte, FL	254	Accreditation w/Type I Recom.	met	--

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APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
10-0262 Good Samaritan Hospital West Palm Beach, FL	326	Accreditation w/Type I Recom.	met	--
11-0007 Phoebe Putney Memorial Albany, GA	450	Accreditation w/Type I Recom.	not met	LSC
11-0009 Peach County Hospital Fort Valley, GA	75	Accreditation w/Type I Recom.	not met	Q, MR, L, I
11-0033 North Lake Regional Atlanta, GA	233	Accreditation w/Commendation	not met	LSC
11-0064 The Medical Center Columbus, GA	417	Accreditation w/Type I Recom.	met	--
11-0108 Early Memorial Hospital Blakely, GA	49	Accreditation w/Type I Recom.	not met	G, M, E, LSC
11-0122 South Georgia Med Ctr Valdosta, GA	288	Accreditation w/Type I Recom.	not met	LSC
11-0184 Douglas General Douglasville, GA	98	Accreditation w/Type I Recom.	not met	LSC
18-0081 Methodist Evangelical Louisville, KY	355	Accreditation w/Type I Recom.	met	--
18-0088 Norton Hospital Louisville, KY	602	Accreditation w/Type I Recom.	not met	I
34-0014 Forsyth Memorial Winston-Salem, NC	854	Accreditation w/Type I Recom.	met	--

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APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
34-0039 Iredell Memorial Statesville, NC	217	Accreditation w/Type I Recom.	met	--
34-0125 Wesley Long Community Greensboro, NC	305	Accreditation w/Type I Recom.	met	--
34-0133 Martin General Williamston, NC	49	Conditional	met	--
34-0155 Durham Regional Durham, NC	451	Accreditation w/Type I Recom.	met	--
44-0020 Hillside Hospital Pulaski, TN	95	Accreditation w/Type I Recom.	met	--
44-0053 Middle Tennessee Med Ctr Murfreesboro, TN	288	Accreditation w/Type I Recom.	met	--
44-0078 Macon County General Lafayette, TN	43	Accreditation w/Type I Recom.	met	--
44-0159 Eastwood Med Ctr Memphis, TN	243	Accreditation w/Type I Recom.	met	--
18 Month Sample				
10-0252 HCA Raulerson Okeechobee, FL	101	Accreditation w/Type I Recom.	met	--

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APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
Conditional Sample				
18-0034 Westlake Cumberland Columbia, KY	80	Conditional	met	—
18-0080 Baptist Regional Corbin, KY	263	Conditional	met	--
REGION V				
Regular Sample				
14-0002 Alton Medical Alton, IL	194	Accreditation w/Type I Recom.	not met	PE-LSC
14-0177 Jackson Park Chicago, IL	328	Accreditation w/Type I Recom.	not met	PE-LSC
14-0207 Grant Hospital Chicago, IL	444	Accreditation w/Type I Recom.	not met	Q, I
14-0253 Hyde Park Hospital Chicago, IL	215	Conditional	not met	MR, L, PE-LSC
14-0276 Foster G. McGraw Maywood, IL	561	Accreditation w/Type I Recom.	not met	I, S, PE-LSC
15-0007 Howard Community Kokomo, IN	249	Accreditation w/Type I Recom.	not met	PE-LSC
15-0001 Johnson Memorial Franklin, IN	165	Accreditation w/Type I Recom.	met	—

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APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
15-0031 Jay County Portland, IN	65	Accreditation w/Type I Recom.	not met	PE-LSC
15-0105 Wabash County Wabash, IN	94	Accreditation w/Type I Recom.	not met	PE-LSC
15-0112 Columbus Regional- Bartholomew County Columbus, IN	325	Accreditation w/Type I Recom.	met	--
23-0013 North Oakland Med Ctr Pontiac, MI	341	Accreditation w/Type I Recom.	not met	PE-LSC
23-0014 Huron Shores Hlth Ctr Rogers City, MI	40	Accreditation w/Type I Recom.	met	--
23-0017 Bronson Methodist Kalamazoo, MI	456	Accreditation w/Type I Recom.	met	--
23-0055 Dickenson County Iron Mountain, MI	107	Accreditation w/Type I Recom.	met	--
23-0143 Grand View Hospital Ironwood, MI	72	Accreditation w/Type I Recom.	met	--
23-0205 Standish Community Standish, MI	33	Accreditation w/Type I Recom.	not met	G, Q, M, FD PE-LSC, I
24-0028 Chisago Health Services Chisago City, MN	49	Accreditation w/Type I Recom.	not met	PE-LSC
24-0139 Mille Lacs Onamia, MN	28	Accreditation w/Type I Recom.	not met	PE-LSC

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FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
36-0096 East Liverpool City East Liverpool, OH	249	Accreditation w/Type I Recom.	met	--
36-0120 Firelands Community Sandusky, OH	90	Accreditation w/Type I Recom.	met	--
36-0132 Fort Hamilton Hughes Hamilton, OH	353	Accreditation w/Type I Recom.	met	--
36-0143 Marymount Hospital Garfield Heights, OH	297	Accreditation w/Type I Recom.	met	--
36-0192 Geauga Hospital Chardon, OH	192	Accreditation w/Type I Recom.	met	--
52-0049 Bellin Memorial Green Bay, WI	242	Accreditation w/Type I Recom.	met	--
52-0160 Appleton Med Ctr Appleton, WI	243	Accreditation w/Type I Recom.	met	--
18 Month Sample				
14-0133 Holy Cross Hospital Chicago, IL	348	Accreditation w/Type I Recom.	not met	I, L, PE-LSC
24-0076 Health One Buffalo Buffalo, MN	65	Accreditation w/Type I Recom.	not met	PE-LSC
36-0107 Bellevue Hospital Bellvue, OH	68	Accreditation w/Type I Recom.	met	--

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FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
36-0131 Alliance Community Alliance, OH	207	Accreditation w/Type I Recom.	not met	PE-LSC
52-0064 Sinai Samaritan Milwaukee, WI	410	Accreditation	met	--
52-0148 Langlade Memorial Antigo, WI	80	Accreditation w/Type I Recom.	met	--
Conditional Sample				
14-0046 Good Samaritan Reg Health Mt. Vernon, IL	195	Conditional	met	--
15-0006 LaPorte Hospital, Inc. LaPorte, IN	227	Conditional	met	--
15-0098 Washington County Salem, IN	70	Conditional	met	--
52-0062 Memorial Hospital of Oconomowoc Oconomowoc, WI	156	Conditional	met	--
52-0092 Shawano Community Shawano, WI	53	Conditional	met	--

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FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
REGION VI				
Regular Sample				
04-0010 St. Mary Rogers Memorial Rogers, AR	165	Accreditation w/Type I Recom.	met	--
04-0048 Bates Memorial Bentonville, AR	63	Accreditation w/Type I Recom.	met	--
04-0072 Stuggart Memorial Stuggart, AR	99	Accreditation w/Type I Recom.	met	--
04-0093 McGehee Desha County McGehee, AR	34	Accreditation w/Type I Recom.	met	--
19-0013 West Calasieu Hospital Sulphur, LA	139	Accreditation w/Type I Recom.	met	--
19-0018 Franklin Foundation Franklin, LA	64	Accreditation w/Type I Recom.	met	--
19-0025 Savoy Medical Center Mamou, LA	101	Accreditation w/Type I Recom.	met	--
19-0071 North Caddo Memorial Vivian, LA	33	Accreditation w/Type I Recom.	not met	LSC
19-0111 Willis-Knighton Med Ctr Shreveport, LA	369	Accreditation w/Type I Recom.	met	--
32-0004 Gerald Champion Memorial Alamogordo, NM	91	Accreditation w/Type I Recom.	met	--

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RS - Rehabilitation Services
RC - Respiratory Care

APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
32-0031 Cibola General Grants, NM	43	Accreditation w/Type I Recom.	met	--
37-0040 Eastern Oklahoma Med Ctr Poteau, OK	84	Accreditation w/Type I Recom.	not met	L, PE-LSC
37-0093 HCA Presbyterian Oklahoma City, OK	348	Accreditation w/Commendation	met	--
45-0007 Sid Peterson Memorial Kerrville, TX	148	Accreditation	not met	L, NM
45-0040 St. Mary of the Plains Lubbock, TX	405	Accreditation w/Type I Recom.	met	--
45-0076 Univ. of Texas Anderson Cancer Center Houston, TX	483	Accreditation w/Commendation	met	--
45-0082 Bee County Regional Beeville, TX	65	Accreditation w/Type I Recom.	met	--
45-0187 Trinity Community Medical Brenham, TX	99	Accreditation w/Type I Recom.	met	--
45-0195 Mainland Medical Center Texas City, TX	211	Accreditation w/Type I Recom.	met	--
45-0229 Hendrick Medical Center Abilene, TX	357	Accreditation w/Type I Recom.	not met	FD
45-0352 Citizens General Greenville, TX	121	Accreditation w/Type I Recom.	not met	Q, P

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Letter Code for Conditions Out of Compliance

F - Federal, State and local laws
G - Governing Body
Q - Quality Assurance
M - Medical Staff
N - Nursing Services
P - Pharmaceutical Services
R - Radiologic Services
L - Laboratory Services
PE - Physical Environment
MR - Medical Record Services
FD - Food and Dietetic Services
I - Infection Control
S - Surgical Services
LSC - Life Safety Code
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APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
45-0379 RHD Memorial Med Ctr Dallas, TX	323	Accreditation w/Type I Recom.	met	--
45-0423 AMI Twelve Oaks Houston, TX	208	Accreditation w/Type I Recom.	met	--
18 Month Sample				
45-0011 St. Joseph's Hospital Bryan, TX	204	Accreditation w/Type I Recom.	not met	P, A
REGION VII				
Regular Sample				
16-0021 Green County Med Ctr Jefferson, IA	49	Accreditation w/Type I Recom.	met	--
16-0039 Cass County Atlantic, IA	61	Accreditation w/Type I Recom.	met	--
16-0094 Waverly Municipal Waverly, IA	45	Accreditation w/Type I Recom.	met	--
17-0020 Hutchinson Hospital Hutchinson, KS	200	Accreditation w/Type I Recom.	met	--

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R - Radiologic Services	LSC - Life Safety Code	

APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
17-0116 Allen County Iola, KS	50	Accreditation w/Type I Recom.	met	--
17-0122 St. Francis Regional Wichita, KS	886	Accreditation w/Type I Recom.	met	--
26-0061 Nevada City Nevada, MO	87	Conditional	not met	FD
26-0095 Independance Regional Independance, MO	366	Accreditation w/Type I Recom.	met	--
26-0177 Liberty Hospital Liberty, MO	102	Accreditation w/Type I Recom.	met	--
28-0030 AMI St. Josephs Omaha, NE	355	Accreditation w/Type I Recom.	met	--
28-0081 Immanual Med Ctr Omaha, NE	381	Accreditation	met	--
Conditional Sample				
16-0055 Decatur County Hospital Leon, IA	49	Conditional	met	--
26-0019 Arcadia Valley Pilot Knob, MO	32	Conditional	met	--

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APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
REGION VIII				
Regular Sample				
06-0015 St. Anthony's Hospital Denver, CO	659	Accreditation w/Type I Recom.	met	--
06-0026 Marcy Medical Center Denver, CO	386	Accreditation w/Type I Recom.	not met	PE-LSC
46-0006 Cottonwood Hospital Murray, UT	213	Accreditation w/Type I Recom.	met	--
18 Month Sample				
35-0002 St. Alexius Med Ctr Bismarck, ND	313	Accreditation w/Type I Recom.	met	--
35-0030 Marcy Hospital Devils Lake, ND	110	Accreditation w/Type I Recom.	not met	L
43-0004 Northern Hills General Deadwood, SD	35	Nonaccreditation	met	--
53-0002 Campbell County Memorial Gillette, WY	119	Accreditation w/Type I Recom.	met	--
Conditional Sample				
06-0046 The Memorial Hospital Craig, CO	42	Conditional	met	--

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APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
27-0051 Kalispell Regional Kalispell, MT	102	Conditional	met	--
REGION IX				
Regular Sample				
03-0034 Southeast Arizona Douglas, AZ	79	Accreditation w/Type I Recom.	met	--
05-0013 St. Helena Hospital Deer Park, CA	165	Accreditation w/Type I Recom.	met	--
05-0028 Mad River Community Arcata, CA	78	Accreditation w/Type I Recom.	met	--
05-0111 Temple Community Los Angeles, CA	170	Accreditation w/Type I Recom.	met	--
05-0125 Alexian Brothers San Jose, CA	204	Accreditation w/Type I Recom.	met	--
05-0277 Pacific Hospital Long Beach, CA	186	Accreditation w/Type I Recom.	not met	M
05-0360 Marin General Hospital Greenbrae, CA	235	Accreditation w/Type I Recom.	met	--
05-0447 Villa View Community San Diego, CA	64	Accreditation w/Type I Recom.	met	--

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APPENDIX E

FY 92 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
167 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
05-0528 Los Banos Community Los Banos, CA	48	Accreditation w/Type I Recom.	not met	L
05-0560 Tustin Hospital Tustin, CA	203	Accreditation w/Type I Recom.	met	—
05-0670 North Coastal Rehab Santa Rosa, CA	61	Accreditation w/Type I Recom.	met	--
12-0006 Castle Memorial Kailua, HI	156	Accreditation w/Type I Recom.	met	--
29-0008 Elko General Elko, NV	52	Accreditation w/Type I Recom.	not met	Q, L, I, O
Conditional Sample				
03-0040 Carondelet Holy Cross Nogales, AZ	31	Conditional	met	—
05-0080 Thompson Memorial Med Ctr Burbank, CA	105	Conditional	not met	Q
REGION X				
Regular Sample				
50-0007 Island Hospital Anacortes, WA	43	Accreditation w/Type I Recom.	not met	A

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APPENDIX F

REGULAR SAMPLE
SAMPLE VALIDATION SURVEYS - VALIDATION DECISIONS
BY SURVEY PERIOD

VALIDATION SURVEY DECISIONS	FY 1991		FY 1992		ALL PREVIOUS REPORT PERIODS (INCLUDING FY 91)	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals in compliance	141	79.7	88	64.7	951	57.6
Hospitals out of compliance	36	20.3	48	35.3	701	42.4
TOTAL SURVEYS PERFORMED	177	100.0	136	100.0	1652	100.0

REASONS FOR NONCOMPLIANCE	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals out of compliance with Life Safety Code only	11	30.6	10	20.8	324	46.2
Hospitals out of compliance with Life Safety Code and at least one Condition of Participation	11	30.6	24	50.0	187	26.7
Hospitals out of compliance for reasons other than Life Safety Code	14	38.8	14	29.2	190	27.1
TOTAL	36	100.0	48	100.0	701	100.0

APPENDIX G

FY 92 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE
34 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
REGION I					
07-0025 Hartford Hospital	861	09/03/92	09/21/92	11/06/92	MR
41-0002 Cranston General	80	03/06/92	03/24/92	06/16/92	Q, M, A, L
REGION II					
None					
REGION III					
None					
REGION IV					
42-0040 Florence General	167	01/24/92	04/28/92	09/09/92	S
11-0030 Humana-Cartersville	80	01/23/92	04/28/92	08/26/92	F, N
REGION V					
14-0013 Proctor Hospital 14-0152	285	09/24/92	10/08/92	12/22/92	Q, FD, I, S A
14-0075 Humana-Michael Reese	955	04/22/92	05/26/92	06/30/93	N
14-0098 Belmont Community	134	10/23/92	12/03/92	07/16/93	E
14-0123 Trinity Med Ctr-East	325	11/17/92	01/20/93	Pending	I
14-0124 Cook County	918	10/29/92	11/06/92	Pending	I
14-0151 Sacred Heart	119	06/17/92	06/26/92	11/02/92	Q

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S - Surgical Services
LSC - Life Safety Code
A - Anesthesia Services
NM - Nuclear Medicine
O - Outpatient Services
E - Emergency Services
RS - Rehabilitation Services
RC - Respirstory Care Services
FT - Fatal Transfusion

APPENDIX G

FY 92 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE
34 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
14-0186 Riverside Med Ctr	336	10/08/92	10/27/92	06/30/93	N
14-0200 Elmhurst Memorial	442	05/01/92	05/27/92	10/28/92	N, PE, I
14-0280 Franciscan Med Ctr	345	11/18/92	12/17/92	Pending	I
14-4009 HCA Riveredge	210	12/02/92	03/05/93	Pending	N, PE
23-0090 Doctors Hospital	101	03/06/92	06/24/92	Closed 08/28/92	L
36-0018 St. Elizabeth MC	617	11/19/92	11/25/92	03/01/93	L
REGION VI					
45-0011 St. Joseph	204	07/31/92	10/16/92	11/17/92	P
45-0046 Memorial Med Ctr	397	05/15/92	06/15/92	12/01/92	Q, N
45-0126 Sun Belt Reg	273	11/03/92	12/01/92	02/17/93	I
45-0365 Dallas Memorial	58	11/15/92	12/16/92	05/20/93	Q, MR, FD, PE, A
45-0417 Baptist-Liberty	30	11/05/92	12/04/92	04/30/93	I
45-0418 Bellairs General	349	08/01/92	09/08/92	01/04/93	Q, N
45-0575 Citizens	30	08/01/92	08/31/92	12/17/92	Q, L, PE, I
45-0630 HCA Spring Branch	365	07/01/92	07/30/92	11/04/92	Q, M
45-0637 Doctors Hospital	135	10/02/92	11/08/92	04/30/93	F, Q, N

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APPENDIX G

FY 92 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE
34 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
45-0547 Humana- Med City	378	07/07/92	08/14/92	08/18/92	I
45-0653 Scenic Mountain	153	08/01/92	09/16/92	02/17/93	Q, FD
45-0765 St. Luke's-Caldwell	44	10/01/92	11/04/92	01/07/93	Q, I, N, FD, E
REGION VII					
16-0083 Mercy Hosp & Med Ctr	500	05/14/92	06/05/92	12/01/93	PE
REGION VIII					
06-0013 Mercy Med Ctr	114	06/24/92	09/15/92	Pending	PE
06-4007 Centennial Peaks	122	06/17/92	10/28/92	12/22/92	N
REGION IX					
03-0014 John C. Lincoln	236	11/03/92	11/18/92	10/12/93	M
05-0251 Lassen Community	59	08/20/92	11/05/92	01/07/93	P
05-3031 Bakersfield	60	08/12/92	09/18/92	11/24/92	N, MR, RS
REGION X					
None					

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FT - Fatal Transfusion

APPENDIX H

ALLEGATION INVESTIGATION SURVEYS
COMPLIANCE AND NONCOMPLIANCE DECISIONS

ALLEGATION INVESTIGATION SURVEY DECISIONS	FY 1991 NUMBER	FY 1991 PERCENT	FY 1992 NUMBER	FY 1992 PERCENT
Hospitals in compliance	109	73	594	95
Hospitals out of compliance	41	27	34	5
Surveys performed	150	100	628	100

REASONS FOR NONCOMPLIANCE	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals out of compliance with Life Safety Code only	0	0	0	0
Hospitals out of compliance with Life Safety Code and at least one Condition of Participation	1	2	0	0
Hospitals out of compliance for reasons other than Life Safety Code	40	98	34	100
TOTAL	41	100	34	100

APPENDIX A

FY 91 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
227 Hospitals

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
40-0001 Ashford Presbyterian Santurce, PR	207	Accreditation w/Type I Recom.	not met	G, L, RC
40-0106 Metropolitan San Juan, PR	180	Accreditation w/Type I Recom.	not met	G, N, P, FD I, E, RC
18 Month Sample				
33-0078 Sisters of Charity Hospital Buffalo, NY	436	Accreditation w/Type I Recom.	met	--
33-0151 St. James Mercy Hornell, NY	155	Accreditation w/Type I Recom.	met	--
33-0277 Corning Hospital Corning, NY	154	Accreditation w/Type I Recom.	met	--
Conditional Sample				
31-0054 Mountainside Montclair, NJ	469	Conditional	met	--
33-0252 Elizabethtown Community Elizabethtown, NY	25	Conditional	met	--
33-0196 Woodhull Memorial Brooklyn, NY	499	Conditional	met	--
33-2021 Monroe Community Rochester, NY	39	Conditional	met	--

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